

Delaware Health Care Commission

# **Annual Report and Strategic Plan, 2009**

Working to promote access to affordable,  
quality health care for all Delawareans

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*Appointed by the Governor*

**Theodore Becker**

*Appointed by the Governor*

**Richard S. Cordrey**

*Ex-Officio as Secretary, Department of Finance*

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**A. Richard Heffron**

*Appointed by the Governor*

**Vincent P. Meconi**

*Ex-Officio as Secretary, Department of Health and Social Services*

**Janice E. Nevin, MD, MPH**

*Appointed by the Governor*

**Dennis Rochford**

*Appointed by the Speaker of the House*

**Henry Smith**

*Ex-Officio as Secretary, Department of Services for Children, Youth and Their Families*

**Frederick A. Townsend**

*Appointed by the Senate President Pro Tem*

# Health Care Commission Members

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**Theodore Becker**  
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*Ex-Officio as Insurance Commissioner*

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# Mission Statement & Key Objectives

**Mission:** To promote accessible, affordable, quality health care for all Delawareans.

## Key Objectives:

**Access-** Promote access to health care for all Delawareans.

**Cost-** Promote a regulatory and financial framework to manage the affordability of health care.

**Quality-** Promote a comprehensive health care system assuring quality care for all Delawareans.

# Introduction

The Delaware Health Care Commission respectfully submits the 2009 Annual Report to the Governor and to the Delaware General Assembly. This report summarizes the extent to which the Commission's mission and goals have been met, the challenges that exist, trends in health care policy and forward thinking strategies that are needed to address them.

Health care issues are at the forefront of discussions among state and national leaders who face an array of challenges related to rising health care costs, declining insurance coverage, and the prevalence of chronic disease. The number of US residents who delay and forgo necessary medical care due to cost concerns has increased significantly over the last four years, according to a study conducted by the Center for Studying Health System Change. Innovative insurance coverage plans, disease management and prevention programming, patient-centered medical homes, workforce recruitment and retention and adoption of health information technology are common initiatives being explored to ensure access to quality, affordable health care for all citizens.

The health care system in Delaware has strengths and challenges. Delaware outperforms regional and national averages on the proportion of the population that is uninsured. However, maintaining insurance coverage levels, particularly for small businesses remain a concern due to rising premium costs. Other concerns include childhood and adult obesity rates, health disparities among diverse racial and ethnic populations, limited access to mental health services, and shortages of health professionals to care for the state's growing and aging population.

This report offers key information about access to health care in Delaware, the cost of health care, and the Commission's strategic plan for the future. The report outlines the areas in need of the most attention and sets forth strategies to address them.



# Five Things You Should Know About Health Care in Delaware

## **About 12 percent of us are uninsured:**

- Approximately 106,000 Delawareans (12.5 percent of the population) are without health insurance. About 26 percent, or 27,233 people who are uninsured are actually eligible for public coverage through either Medicaid (17.6 percent or 18,394 people) or the Delaware Healthy Children Program – S-CHIP (8.5 percent or 8,840 people). Another 20 percent (about 20,720 people) are eligible for CHAP, the Community Healthcare Access Program administered by the Health Care Commission.

## **Income and where we work are good predictors of health insurance coverage:**

- For example, the probability of being uninsured is linked to individuals' income levels, which are linked to their level of education and where they work. Small businesses and organizations are less likely to offer health insurance coverage to their employees, because of rising costs of health care services and insurance premiums. The higher the level of education, the higher the income and the greater the chance of having a job that offers insurance or the financial stability to purchase it. The exception is for the poor, where most uninsured adults that are low to moderate income are not eligible for Medicaid or S-CHIP. Medicaid coverage is primarily available to low-income children, parents, pregnant women, people with disabilities, and the elderly. The average annual cost of employer-sponsored family coverage rose 5% in 2008 to \$12,680, with employees on average paying \$3,354 out of their paychecks to cover their share of the cost. This has the greatest impact on lower income workers who cannot afford these plans without employer-based contributions.

## **We face significant, continued shortages of health professionals:**

- Delaware, like other states, faces a shortage of health professionals. Specifically, Kent County, Sussex County, and parts of the City of Wilmington have been federally designated as health professional shortage areas. There are particular shortages among primary care physicians, dentists, nurses and mental health professionals. These shortages threaten the ability of health care facilities in Delaware to provide timely access to quality care.

## **Racial and ethnic disparities persist:**

- There are disparities in the burden of illness and death experienced by black, Hispanic, and Asian populations when compared to the population as a whole. Black infant mortality rates are higher than white rates in all three Delaware counties, according to Delaware's Health Statistics Center 2001-2005.<sup>1</sup> Overall, the rate in DE was 17.1 percent for Black, compared to 6.8 percent for whites, and 7.2 percent for Hispanics. According to the *2007 National Healthcare Disparities Report*, Agency for Healthcare Research & Quality, Hispanics receive poorer quality care than non-Hispanics and data indicates that this trend is getting worse, not better. And, in preventative care, the

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<sup>1</sup> 2008 Delaware Racial and Ethnic Disparities Health Status Report Card. Delaware Health and Social Services, Division of Public Health.

Hispanic population has the lowest percentage of people accessing regular dental care and colon cancer screenings --- two key indicators of a population's ability to stay healthy. While the causes are complex and difficult to identify, disparities may be attributed to health care delivery, socioeconomic status, culture, language, environment, genetics, and personal behavior (i.e. smoking, poor nutrition, lack of physical activity).

**We spend slightly more, but health care is a major provider of jobs:**

- Overall, \$6.2 billion was spent on personal health care (about \$7,197 per person) in Delaware in 2007, compared to \$5 billion in 2003 and \$5.9 billion in 2006.<sup>2</sup> The annual rate of growth averages about 5 percent per year. The largest share of spending is on hospital care (39%), physicians (25.4%), and prescription drugs (14.8%). The health care sector is a significant source of employment for the Delaware economy, accounting for 11% of the total workforce and 11% of all reportable wages. Today, 45,227 people are employed in the health care industry (Health sciences), compared to just 29,000 in 1990. The Delaware Department of Labor statistics show that healthcare occupations comprise 12 of the 20 fastest growing occupations for the projected period between 2006-2016.

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<sup>2</sup> *Total Cost of Health Care in Delaware*. (2007). Simon Condliffe and Edward C. Ratledge. CADSR, University of Delaware.

# Executive Summary

All Delawareans need and deserve access to reliable, affordable, quality health care. Achieving this goal requires a comprehensive set of strategies to address health care access, cost, and quality in the state. The Health Care Commission oversees five major initiatives to meet its mission and goals:

1. **Uninsured Action Plan** – exploring strategies to preserve and expand health insurance coverage through the *State Planning Program* and linking uninsured citizens with reliable health homes and affordable care through the *Community Healthcare Access Program (CHAP)*.
2. **Information & Technology** – developing a statewide clinical health information exchange through the *Delaware Health Information Network (DHIN)*.
3. **Health Professional Workforce Development** – assuring an adequate supply of health care professionals through the *State Loan Repayment Program* and the *Health Workforce Data Committee* and expanding educational opportunities for Delawareans through the *Delaware Institute of Medical Education and Research (DIMER)* and the *Delaware Institute for Dental Education and Research (DIDER)*.
4. **Research & Policy Development** – performing ongoing research and providing accurate information for state policy-makers.
5. **Specific Health Care Issues & Affiliated Groups** – addressing specific health care conditions that are so prevalent they warrant special attention and working in cooperation with other bodies created by the state for this purpose.

## 1. Uninsured Action Plan

### ***State Planning Program***

The State Planning Program, launched in 2001, permits continued identification and analysis of both short-term and long-term health insurance coverage options for Delaware. Over the course of the past six years the Commission has reviewed and analyzed over twenty options. After extensive consideration, two approaches were identified as the most appropriate for Delaware. The Commission has adopted a two-pronged strategy to preserve existing insurance coverage (targeting small group employers) and to expand coverage to all uninsured Delawareans (targeting low-income residents).

In 2009, the Commission will re-introduce legislation seeking to reform current small group insurance regulations (Chapter 72, Title 18) to make them easier to understand and enforce, and to reduce rate variation so premiums are more stable and predictable. Rising health care costs and insurance premiums have made it difficult for some businesses and non-profit organizations to afford coverage for their employees. High costs are often passed on to low-income employees, and as a result, coverage may be dropped. The Commission will cooperate and work with the State Insurance Department in these and other endeavors.

The second part of the two-pronged, short-term strategy is the expansion of insurance coverage. Strategies are being considered to aggressively enroll children that are eligible but not yet enrolled in S-CHIP, a coverage initiative under the Delaware Healthy Children Program. Additionally, an analysis of delivery designs, including cost estimates, will be conducted for a program that would provide preventive and primary care services to a broad array of Delawareans to improve health. Lastly, a marketing study of how and why consumers use community health centers was expanded in 2008 to include additional federally qualified health centers (i.e. Delmarva Rural Ministries and La Red Health Center), and based on the key findings, marketing strategies will be developed to promote the use of these facilities in 2009.

The Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In 2008, two models were the focus for achieving universal coverage: traditional single-payer and a "building blocks" model that makes use of existing systems based on reforms enacted in the state of Massachusetts. Throughout 2009, a micro-simulation analysis of the cost of implementing these approaches will be completed.

### ***Community Healthcare Access Program (CHAP)***

As the number of uninsured Americans continues to grow, some states are striving to create a health system "safety net" that provides affordable and appropriate care to uninsured citizens. CHAP is Delaware's health system "safely net" and it connects low-income uninsured Delawareans with physicians and health care resources such as prescription medication, physical therapy, radiology, and laboratory services offered at reduced cost. Patients with incomes below 200 percent of the federal poverty level (FPL) who are ineligible for other state or federal medical assistance are matched with doctors at hospitals, private practices, and community health centers throughout the state. The target population for CHAP is comprised of approximately 20 percent of the state's uninsured population, about 20,720 adults. Since the inception of the program in 2001, and as of August 31, 2008, CHAP has served over 16,923 uninsured patients and enrolled 3,253 in other state and federal medical assistance programs such as Medicaid and the Veteran's Administration.

In 2007 and 2008, a new component was added to the CHAP program to improve health status by implementing a health promotion and disease management component, focused on high risk and high need patients. This was accomplished by administering health risk assessments and health home adherence to best practices through chart reviews. Over the last year, there were improvements in smoking cessation, services for diabetics, and some lifestyle improvements for people with hypertension and flu shots for asthmatics.

In 2009, program evaluation will continue including a new evaluation dimension on birth outcomes and prenatal care. In addition, coordination and consolidation of activities to gain greater efficiencies and improved effectiveness of the program will be pursued. Specifically, efforts will focus on outreach and enrollment activities within CHAP and across other programs. Furthermore, case management will continue in 2009 for CHAP patients identified as high risk, with prescription assistance included. On average, 95-97% of requests for prescription assistance are filled resulting in an average quarterly savings for CHAP patients of about \$75,000.

## **2. INFORMATION & TECHNOLOGY**

### ***Delaware Health Information Network (DHIN)***

The use of information and technology in the health care system has emerged as a national priority, and Delaware is recognized as a leader in the development of a statewide clinical information exchange network. In 2008, DHIN was the first Health Information Exchange (HIE) to successfully connect with the federal government (Federal CONNECT) and successfully secure a connection with another HIE (CareSpark). The intent of DHIN is to further enhance patient safety & quality of care by providing a patient centric historical record from multiple healthcare providers (i.e. hospitals, physicians, laboratories, pharmacies, etc.) at the time and place of care, including medication history, hospitalizations, clinical reports, and test results. Ultimately, this exchange network will help improve clinical decision-making and reduce time and financial costs resulting from unnecessary duplication of diagnostic tests and procedures performed in the absence of data and patient information.

Implementation of Phase 1 of DHIN, secure results delivery, was successfully completed in March 2007. As of October 2008, DHIN provides a streamlined results distribution system that delivers approximately 80 percent of lab tests and hospital admissions to over 448 physician users at three hospitals and 73 physician practices (at 166 practice locations) throughout the state.

In 2009, DHIN will implement Phase 2: patient centric record search function, including clinical results and reports as well as medication history. Additional functions to be rolled out in 2009 include electronic order entry from an Electronic Health Record (EHR) and a patient portal. The Commission will continue to promote and expand provider enrollment and usage of the network, provide staff support, and facilitate communication between DHIN and the General Assembly. The project is supported financially with State funds, private contributions, and federal contracts with the U.S. Agency for Healthcare Research and Quality (AHRQ) and the National Health Information Network (NHIN).

## **3. HEALTH PROFESSIONAL WORKFORCE DEVELOPMENT**

### ***Delaware Institute of Medical Education and Research (DIMER)***

### ***Delaware Institute for Dental Education and Research (DIDER)***

DIMER and DIDER were established by the Delaware General Assembly to address the shortage of health professionals in Delaware. They provide enhanced opportunities for Delaware residents to obtain medical and dental education as a cost effective alternative to the State establishing its own schools for these professions. Through DIMER, financial support is provided to Jefferson Medical College and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots for Delaware students. Scholarships and tuition supplements are also available for the students. In 2009 the Commission will continue to promote health professions to young people while striving to increase the geographic, racial, and ethnic diversity of Delawareans participating in the Jefferson and PCOM partnerships.

In 2009, the Commission will continue to promote a fairly new agreement between DIDER and the Maurice H. Kornberg School of Dentistry at Temple University in Philadelphia, Pennsylvania. Through this partnership, financial support is provided to Temple in exchange for reserved admission slots, providing Delaware residents that meet academic admissions

requirements with an opportunity to receive training at a highly regarded regional dental school. The partnership also promotes opportunities for participating dental students to complete externship and residency training programs at facilities in Delaware.

### ***State Loan Repayment Program (SLRP)***

This program is designed to recruit health care professionals to federally designated health professional shortage areas throughout the state. Participating clinicians provide health services in an underserved area for a minimum of two years in exchange for payments toward their educational loans. The program has been very successful since increasing the maximum award to \$70,000 for a two-year contract and adding twelve new specialties to the list of eligible clinicians. Since the program's inception in 2001, nine dentists, thirty-one physicians, three certified nurse midwives and three certified nurse practitioners have been placed in underserved areas of the state. In 2009, the Commission will continue efforts to market the program, with a specific focus on the recruitment of a diverse group of health professionals. For example, research has shown that strategies to recruit students from rural areas are successful as they are more inclined to remain and practice in rural and underserved areas beyond their loan repayment obligation.

### ***Addressing Shortages in the Health Workforce***

The Health Workforce Development Committee is tasked with identifying needs for health workforce information, collecting data and providing resources to coordinate strategies to predict and prevent shortages. This committee uses existing data collected statewide and other national data to make recommendations to improve the supply, distribution and diversity of our health professional workforce to ensure that Delaware meets its future needs.

In 2008, the Health Workforce Development Committee completed a comprehensive study designed to assess the supply and distribution of allied health professionals and pharmacists, providing valuable information about estimated shortages among these members of the health workforce.

In 2009, the committee will determine policy recommendations for implementation. Specifically, the work of the committee will consider the following:

- Aging population
- Address mental health services as an essential component to overall health
- Increased diversity of the population
- Aging workforce
- Barriers to the workplace
- Increased burden of chronic disease
- Regional workforce and training issues
- Innovative financing for implementation strategies

#### **4. RESEARCH & POLICY DEVELOPMENT**

In order to provide accurate and up-to-date information to policy and decision-makers, the Commission performs ongoing research and publishes findings in reports made available to the public. In 2009, the “*Delawareans Without Health Insurance*” report will be continued. Additionally, the “*Total Cost of Health Care in Delaware*” report will be continued and ways to restructure the report to make it more useful will be identified, which may include the replication of a 1999 study on the effects of cost shift.

#### **5. SPECIFIC HEALTH CARE ISSUES & AFFILIATED GROUPS**

Occasionally, specific health care conditions are so prevalent in Delaware that they warrant special attention. In 2009, the Commission will continue to focus attention on the following issues: mental health, chronic illness, racial & ethnic health disparities, and health insurance pooling. In addition, the Commission is often assigned to cooperate with various bodies created by the General Assembly. Staff will participate and a representative of the Commission will be designated to serve on the *Health Resources Board (HRB)*, which operates with staff support provided by the Bureau of Health Planning and Resources Management within the Division of Public Health, reviewing applications for a Certificate of Public Review. The Certificate of Public Review process assures that there is public scrutiny of new health-related capital construction projects in the State. In 2009, the Commission will consider ways to coordinate activities with the Health Resources Board, with particular attention on the CHAP program and the HRB’s charity care policy to examine whether opportunities exist to ensure that the two programs are more seamless. Additionally, Commission representatives are assigned to serve on the *Health Fund Advisory Committee*, which provides guidance on the allocation of funds received from the State’s Tobacco Master Settlement Agreement.

# Status of Health Care in Delaware

The rising costs of health care services and insurance premiums have brought health care issues to the forefront of public discussions statewide, regionally, and nationally. The Commission's research indicates that Delaware continues to outperform other states in the region and the nation in terms of the percentage of uninsured citizens. Delaware, however, spends more money per capita on health care than other states, due in part to increased utilization and cost of care.

The Commission is required to report on the state of health care in Delaware annually. It uses the following means to issue this report:

**Access:**

- Health Insurance Coverage
- Health Professional Supply

**Cost:**

- Total Health Spending in Delaware

**Quality:**

- Health Indicators
- Disparities



# Health Care – Access

Access to health care is measured by two indicators:

1. Access to health insurance coverage
2. Supply and capacity of health professional workforce

## **1. Health Insurance Coverage**

The Commission tracks the number and characteristics of the uninsured population in Delaware annually through a contract with the Center for Applied Demography and Survey Research, College of Human Services, Education and Public Policy, University of Delaware. Research shows that the presence of health insurance increases the likelihood that people will have access to health care services when they need them. The uninsured generally face greater barriers to preventive and primary care, and are less likely to receive needed health care services on a timely basis. The uninsured are less likely to receive proper tests and treatments for chronic conditions, such as diabetes, which can increase their chances of having medical complications. The uninsured are also less likely to receive timely screenings for cancer and cardiovascular disease, and are more likely to experience later stage diagnosis.<sup>3</sup> Additionally, a person without insurance is more likely than their insured counterparts to use the emergency department, the most costly and often inefficient source of health care services.

## **Uninsured in Delaware**

In 2007 about 12.5 percent of Delaware's total population (pop = 862,000 people) went without health insurance, representing approximately 106,000 uninsured Delawareans<sup>4</sup>. This is an increase from 12.2 percent (101,000 people) in 2006.<sup>5</sup> In the US Census Bureau report, *"Income, Poverty, and Health Insurance Coverage in the United States: 2007,"* Delaware fairs better than the nation who respectively had an uninsured rate of 15.4% and better than states in the region (MD 13.6%; NY 13.4%; NJ 15.2%).<sup>6</sup>

### ➤ *Who are the uninsured in Delaware?*

- |                               |   |
|-------------------------------|---|
| • 24% are under the age of 19 | • 35% with household income over \$50,000 |
| • 58% are working adults      | • 60% own or are buying their home        |
| • 56% are male                | • 8 % are self-employed                   |
| • 70% are White               | • 20% are non-citizens                    |
| • 20% are Hispanic            | • 83% are above the poverty line          |

<sup>3</sup> This information has been documented in several studies, including *Care Without Coverage: Too Little, Too Late*. Committee on the Consequences of Uninsurance, Board on Health Care Services, Institute of Medicine. National Academy Press, 2002.

<sup>4</sup> To improve accuracy, the uninsured figures are based on a three-year moving average (2005-2007), which removes year-to-year fluctuations due to random variation associated with sample surveys.

<sup>5</sup> *Delawareans Without Health Insurance* (2007). Edward Ratledge. Center for Applied Demography and Survey Research, University of Delaware.

<sup>6</sup> *Income, Poverty, and Health Insurance Coverage in the U.S.: 2007*. (August 2008). US Census Bureau.

- |  |
|--|
| <ul style="list-style-type: none"><li>• 18% live alone</li></ul> |
|--|

In developing policies and programs to reduce the number of uninsured in Delaware, one way to examine the population is by income level and insurance coverage eligibility.

Consider the following:

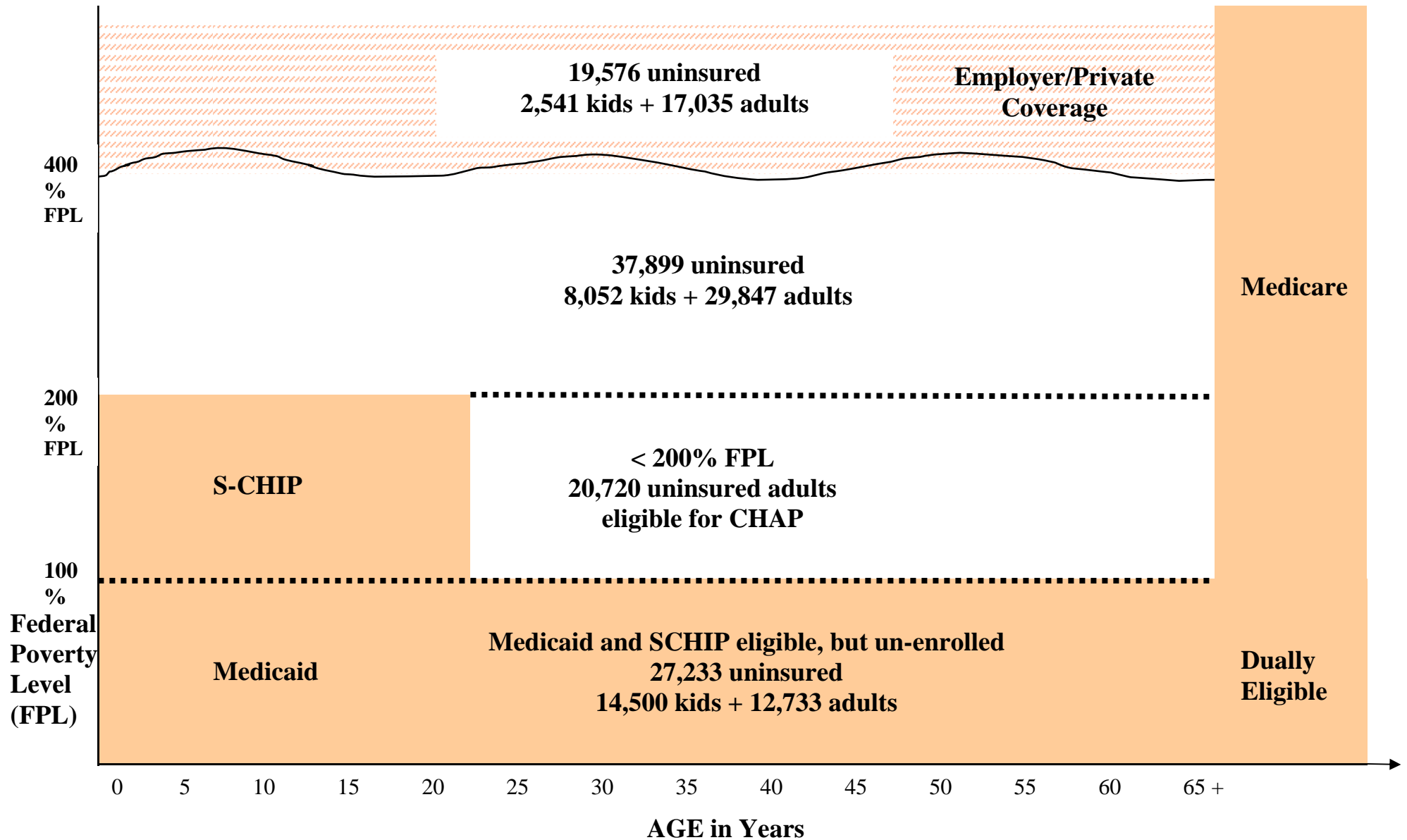
- Nearly 26 percent of the uninsured population, approximately 27,233 people, are eligible for existing public coverage but are not enrolled. This includes about 12,733 adults and 5,660 children in families with incomes below 100 percent of the federal poverty level (FPL), which is \$21,200 for a family of four<sup>7</sup>. Most of this group is eligible for Medicaid. Additionally, 8,840 children in families with incomes between 100 - 200 percent FPL are uninsured and eligible for the Delaware Healthy Children Program (Delaware's S-CHIP coverage plan). Strategies for addressing this group include outreach, education and identification and reduction of barriers to enrollment.
- About 20,720 people, or 20 percent of the uninsured population have incomes between 100 - 200 percent FPL. Their income is too high to be eligible for Medicaid and many in this group can not afford private health insurance. This is the current target population for the Delaware Community Healthcare Access Program (CHAP).
- Approximately 54 percent, or 57,475 uninsured people in Delaware have family incomes above 200 percent FPL. This includes 10,593 children and 46,882 adults. This group includes many people who are self-employed or work for small businesses/non-profit organizations that tend not to offer or provide insurance coverage. They may also be part-time or seasonal workers or employees in the service or construction industries, which tend to have the highest levels of uninsured employees. Long-term, comprehensive reform strategies will include this group in addition to the other two.

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<sup>7</sup> *Federal Register*, Vol. 73, No. 15, January 23, 2008, pp. 3971-3972.

# Who are the 106,000 Uninsured by Poverty Level?

Source: *Delawareans without Health Insurance*. (2007). Center for Applied Demography & Survey Research, University of Delaware  
US Bureau of Census, Current Population Survey, March 2005-2007. Table 3-1 and Table 4-3.



**Uninsured in Delaware by Age and Poverty Level-**  
(3-year average 2005-2007)<sup>8</sup>

<b>Uninsured by Poverty</b>	<b>Uninsured Age 0-18 years</b>	<b>Uninsured Age 19+ years</b>	<b>Total</b>	<b>Family of 4, FPL (2008)</b>
<100 FPL	5,660*	12733*	18,393	\$21,200 @ 100%
100-199% FPL	8,840 <sup>#</sup>	20,720 <sup>^</sup>	29,560	\$42,400 @ 200%
200-299% FPL	4927	18065	22992	\$63,6100 @ 300%
300-399% FPL	3125	11782	14907	\$84,800 @ 400%
400-499% FPL	1367	5844	7211	\$106,000 @ 500%
500+ FPL	1,174	11,191	12,365	>\$106,001

\* Income eligible for Medicaid.

# Income eligible for the Delaware Healthy Children Program (S-CHIP coverage plan) and the Delaware Prescription Assistance Program (DPAP).

<sup>^</sup> Income eligible for the Delaware Community Healthcare Access Program (CHAP).

In addition to age and income level, many factors play a role in the likelihood that a person is uninsured. Factors include, but are not limited to place of employment, place of residence, household composition, race and ethnicity.

### **Employment**

Employees of small firms are at a greater risk of being uninsured than people who work for larger firms. Nearly 25 percent of Delawareans that work for firms with fewer than 25 employees and 14 percent of those that work for firms with 25-100 employees are uninsured. This is up from 20 percent and 12 percent respectively in 2003, serving as an indicator that small businesses are having greater difficulty providing coverage for their employees. In terms of industry, construction workers have the highest rates of uninsurance (32 percent) followed by people in the trade industry (14 percent) and service industry (14 percent). Those who are self employed are more likely to be uninsured (24 percent) compared to 12 percent of private sector workers and 5 percent of government employees. Overall, the number of employers offering health insurance to their workers is decreasing steadily. According to a recent study by the Kaiser Family Foundation, 63 percent of companies offered insurance to their employees in 2008, compared with 66 percent in 2003 and 69 percent in 2000.<sup>9</sup> The latest trend in employer health benefits is offering employees a range of wellness programs including weight loss programs, gym membership discounts, smoking cessation programs, a personal health coach, and classes in nutrition or web-based resources on healthy living.

<sup>8</sup> Source: *Delawareans without Health Insurance*. (2007). Center for Applied Demography & Survey Research, University of Delaware. US Bureau of Census, Current Population Survey, March 2005-2007. Table 3-1.

<sup>9</sup> Kaiser Family Foundation and Health Research and Educational Trust. Employer Health Benefits-2008 Summary of Findings. <http://ehbs.kff.org/images/abstract/7791.pdf>

Health and wellness programs are proven prevention strategies that give people the tools needed to live healthier lifestyles and self-manage chronic diseases.

### **County Residence**

People who live in Sussex County are more likely to be uninsured (16.5 percent) than people who reside in Kent County (12.9 percent) and New Castle County (11.1 percent). However, although the rate of un-insurance is lowest in New Castle County, the actual number of uninsured people is higher there than the other counties. Almost 54% of the uninsured reside in New Castle County. Approximately 57,300 people who live in New Castle County are without health insurance compared to Kent County where 21,300 people are uninsured and to Sussex County where 27,100 people are uninsured. Notably, rates of un-insurance are growing most rapidly in Kent and Sussex Counties.

### **Household Composition**

Two-person and four-person households are the least likely to report lacking health coverage (10.4 and 10.2 percent respectively), while single person households are the most likely to report being uninsured (13.8 percent). The two and four person households have a higher probability of including a married couple with two incomes and more opportunities to obtain insurance coverage through employment.

### **Age**

Young adults (18-29 years old) are more likely to be uninsured than children and older adults. This is the result of multiple factors: they are less likely to be married, more likely to have lower paying jobs that do not provide health coverage, and their income levels are generally lower, making it more difficult for them to purchase insurance. Because people in this age group tend to be healthy, it may seem reasonable to them not to expend their relatively limited resources on purchasing health insurance.

Age	Percent Uninsured
0-4 years	12.1%
5-17 years	11.5%
18-29 years	21.2%
30-64 years	13.2%
65+ years	Not measured due to Medicare coverage

### **Race and Ethnicity**

Delawareans who classify their race as black have nearly a 16 percent higher risk of being without health insurance coverage as those that report being white. In terms of ethnicity, 37 percent of Hispanics are uninsured (a significant increase from 25 percent in 2003), compared to 10.8 percent of non-Hispanics. (Note- race and ethnicity are measured as separate and independent variables.)

## **Policy Implications**

Because of the adverse consequences of being without health insurance, significant focus is appropriately placed on reducing the number of uninsured Delawareans. A key area of attention is on those people eligible but not enrolled in existing coverage programs. Another key area of concern is small business/nonprofit employees with less access to coverage than employees of large firms. The Commission's strategies to preserve current levels of employer-based coverage are just as significant as those to expand coverage to the uninsured.

## **2. Number of Health Professionals**

Achieving adequate access to care requires a sufficient number and distribution of health care professionals throughout Delaware to provide services. There are pockets within the state that are underserved. For example, the federal Health Resources and Services Administration (HRSA) has designated significant sections of Wilmington (New Castle County) and all of Kent and Sussex Counties as health professional shortage areas for primary care physicians and dental care providers. Most recently, Delaware was granted approval for federal shortage area designations for mental health professionals.

Throughout Delaware there are shortages of primary care physicians<sup>10</sup> and mental health providers<sup>11</sup>, particularly downstate in Kent and Sussex Counties. The shortage of psychiatrists and other mental health professionals that treat children is particularly significant in Sussex County. There is also a well documented, statewide shortage of nurses that is expected to worsen over the next decade, due in part to shortages of teaching faculty at colleges and universities in Delaware.<sup>12</sup> Based on projections, thousands of health professionals need to be educated and/or recruited over the next five to ten years to meet the needs of Delaware's growing and aging population.<sup>13</sup>

Additionally, critical shortages among radiological technicians, laboratory technicians, pharmacists, and other allied health professionals are reported among practitioners "in the field". In 2008, the Allied Health Professionals study was completed. The study was designed to assess the supply and distribution of allied health professionals and pharmacists in the state and was completed in partnership between the Health Care Commission, Division of Public Health and the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware. The study surveyed almost 5,000 allied health professionals, including pharmacists, paramedics, physical therapists, physical therapists assistants, physician assistants, respiratory practitioners, speech/language pathologists, therapeutic optometrists and radiologic specialists. Four key areas were highlighted in the study: current supply and distribution, education, diversity, and barriers to the workplace.

To help recruit health care providers and ensure an adequate supply and distribution of a health professional workforce, the Commission administers a number of programs such as the State Loan Repayment Program. Since the program's inception in 2001, a total of 46

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<sup>10</sup> Primary Care Physicians in Delaware 2006, prepared for the Delaware Division of Public Health by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>11</sup> Mental Health Professionals in Delaware 2005, prepared by Edward C. Ratledge, Center for Applied Demography and Survey Research, University of Delaware.

<sup>12</sup> Solving the Nursing Shortage in Delaware, Key Findings and Recommendations, prepared by the Delaware Health Care Commission's Committee on Nursing Workforce Supply, March 2002.

<sup>13</sup> Delaware Healthcare Association. "Acute Care Hospitals and Health Systems Workforce Needs." June 2004.

professionals have been placed in underserved areas. This is comprised of nine dentists, thirty-one physicians, three certified nurse midwives and three certified nurse practitioners that have been placed in underserved areas of the state. Fourteen practitioners were placed in New Castle County, ten in Kent County and twenty-two in Sussex County.

The Commission also oversees the Delaware Institute of Medical Education and Research (DIMER) and the Delaware Institute for Dental Education and Research (DIDER), which provide enhanced opportunities for Delawareans to pursue a medical or dental education and help recruit qualified clinicians to practice in the state. Through financial agreements with DIMER and DIDER, annual admissions slots are held for Delawareans at three reputable medical and dental schools in the region: Jefferson Medical College (20 slots), Philadelphia College of Osteopathic Medicine (5 slots) and the Temple University School of Dentistry (6 slots). Also, through the generosity of the Delaware General Assembly funds are provided to the Delawareans attending these schools in the form of tuition stipends. In 2007, the average medical student in the U.S. graduated \$139,000 in debt.<sup>14</sup> Medical school tuition and fees have increased by 165 percent among private schools. The cost of medical school education and the enormous burden of student loan debt may deter many young people from pursuing careers in medicine, which is why the tuition stipends have been very helpful to students who attend these private schools.

The Commission's Health Professional Workforce Development Committee is a public/private sector collaborative partnership to develop strategies to predict and prevent health workforce shortages. This Committee works to streamline the fragmented data collection systems that exist throughout the state today, examines the level of skill, education and training for a competent workforce, and in 2009, will propose the development of sustainable policy recommendations to improve the supply, distribution and diversity of our health professional workforce. The Committee works closely with the Division of Professional Regulation to determine options for the collection of valuable health professional data through the on-line licensure process. Discussions are also underway in cooperation with the Division of Substance Abuse and Mental Health to create an online mental health professional directory as a resource for referrals within the provider community as well as consumers of health care services.

The Committee completed a critical and comprehensive study in 2007 that reviewed the health education programs available in Delaware including the supply of health professional faculty at colleges and universities, and the length of time required for students to complete their education and enter the workforce. The goal was to determine whether Delaware is producing an adequate supply of health professionals to meet the needs of the state's growing population, and to better understand the unique components of educational programs, such as how long it takes to train various professions as well as any particular challenges that might exist in the "educational pipeline" for our health workforce. The Committee was also instrumental in shaping the design of the 2008 Allied Health Professionals capacity study and will determine next steps based on the key findings.

In 2009, the Health Professional Workforce Development Committee will develop policy recommendations for health workforce development issues considering the following:

- Aging population

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<sup>14</sup> *Medical Student Debt: A Primary Concern*. (Fall 2008). Bruce Auerbach, MD '78. Temple Medicine Bulletin.

- Address mental health services as an essential component to overall health
- Increased diversity of the population
- Increased burden of chronic disease
- Aging workforce
- Regional workforce and training issues
- Innovative financing for implementation of strategies
- Barriers to the workplace



## Health Care – Cost

Overall, \$6.2 billion was spent on personal health care (about \$7,197 per person) in Delaware in 2007, compared to \$5 billion in 2003 and \$5.9 billion in 2006.<sup>15</sup> Comparatively, the United States spends \$7,439 per person on health care.<sup>16</sup> Delaware is generally in the mainstream among states with regard to personal spending, but is expected to see growth in consumption of services as the population increases and ages. While medical prices (the cost of services) are inflating at 4 percent per year, the total cost of care in Delaware has risen about 5 percent per year since 2001. The total cost of care is affected by three variables: population size, price of services, and utilization.

Health care spending in the U.S. and Delaware is poised to increase, largely due to a growing population and the aging Baby Boomer generation, but also fueled by advances in technology and greater consumption of services and treatments, such as prescription drugs. As the number of people in the state increases, the total cost of care will also increase. Since 1990, more than 177,000 people have joined Delaware's population (a growth rate of 28 percent). Collectively, they will increase total health expenditures by almost \$1 billion annually.

Utilization increases are largely driven by the relaxation of tight managed care restrictions, which held overall spending down in the mid 1990's. Now, hospitals, physicians, and other specialists are experiencing rising patient demand, which is a driver in rising health care expenditures. Also, the drug sector is rapidly expanding and the outlook for expenditures is strong continued growth.

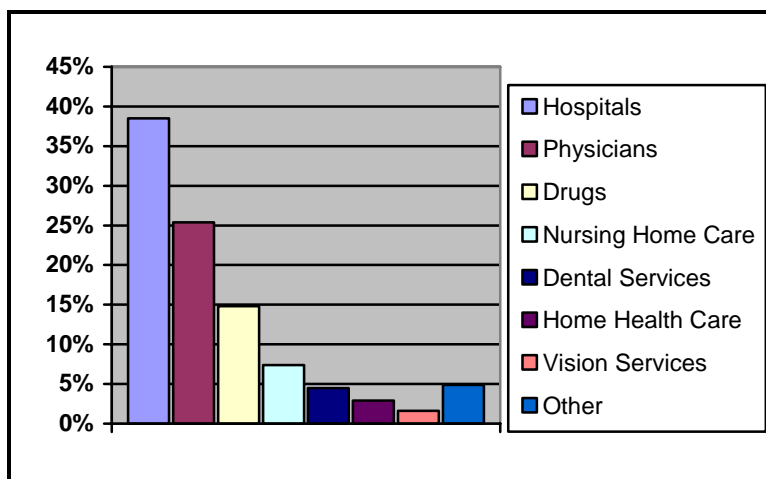
As a share of total health care expenditures, 39 percent is spent on hospital care and 25 percent on physicians and other health professionals. Most of the remainder is comprised of drugs (15%), nursing home care (7%), and dental care (5%). The study also found that individuals pay out-of-pocket for the majority of costs for drugs, vision products, and dental services. The government pays for the majority of hospital charges, and private insurers are the primary payers for physicians.

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<sup>15</sup> *Total Cost of Health Care in Delaware*. (2007). Simon Condliffe and Edward C. Ratledge. CADSR, University of Delaware.

<sup>16</sup> National Health Expenditures, Forecast summary and selected tables, Office of the Actuary in the Centers for Medicare & Medicaid Services, 2008. Accessed March 20, 2008.

### Personal Health Care Expenditures in Delaware: Share of Total Expenditures in 2007 by Category



Source: Center for Applied Demography and Survey Research, University of Delaware.

The structure of the health care industry is becoming leaner and more efficient. While the population has increased just over 19 percent during the period of 1993 to 2004, the number of hospital beds, admissions and inpatient days declined. Much of this can be attributed to technological improvements, allowing for fewer hospital admissions, shorter lengths of stay and an increase in the provision of outpatient services.

### Economic Impact

While the U.S. devotes 16 percent of gross domestic product to health care and Delaware only 11 percent, health care remains an increasing portion of the total output in both the state and the nation. This is expected to increase between now and 2030. Between 2010 and 2030 the 45-54 year age group is projected to actually decline by about 15,000 while the over-65 year group will increase by over 100,000. This will place increased demands on the health care sector and contribute to its consuming a greater portion of the state GDP.

The health care industry serves as an engine for job growth in Delaware. A large proportion of the state's workforce is in the health care sector, with 11 percent of the workforce and 11 percent of reportable wages. Today about 48,000 people are employed in the health care industry, compared to 29,000 people in 1990. The growth of employment in the health services industry is accelerating and projections show that employment in the industry will continue to grow. In 2007, medical services employment growth rate was 2.7%. Hospital employment, by far the largest segment of medical services employment, has exceeded 2% annual growth since 2000.

The expansion of health care providers in the state will place further demands on an already undersupplied work force. The Delaware Department of Labor forecasts that Health Care and Social Assistance will account for 17% of total job growth between 2006 and 2016, just passing the current largest industry Retail Trade. Over the next decade, almost one out of every five new jobs in Delaware will be created in the Health Care and Social Assistance Industry. Of the 20 fastest growing occupations in Delaware (2006-2016), 12 are health-related. Medical assistants, massage therapists, physician's assistants, physical therapy assistants, and pharmacy technicians are all expected to be in high demand.

### **Delaware Average Annual Salary of Selected Health Occupations**

<b>Occupation</b>	<b>Average Annual Wages</b>
Licensed Practical Nurse (LPN)	\$44,328
Registered Nurse (RN)	\$61,295
Dental Hygienist	\$60,820
Radiologic Technologists & Technicians	\$46,464
Pharmacists	\$90,697
Optometrist	\$147,510
General Practitioner/Physician	\$145,960

**Source: Delaware 2016 Occupation & Industry Projections, 2006 Average Annual Wages, Office of Occupational and Labor Market Information, Delaware Department of Labor.**

### **Cost Shift<sup>17</sup>**

Cost shifting is defined as the process by which health care providers recover the unpaid or underpaid costs of care delivered to one patient population by collecting above cost revenues from another patient population. The process is a common dynamic in the health care marketplace and occurs in different contexts and settings. In the case of hospitals and physicians, cost shifting has been attributed to two factors: below-cost reimbursement rates paid by public programs such as Medicare and Medicaid, and uncompensated care losses due to bad debt or charity care.

National markup of charges over costs continues to grow and now stands at more than two and a half times costs. Private payer payment-to-cost ratio is also on the rise. In 2005, private payer payment-to-cost ratio was 1.24 - the highest it has been in 10 years. Hospital margins in the nation and neighboring states are 5-10 percent. The national hospital margin figure is the highest. Delaware's hospital margin measure exhibits some volatility. If averaged, the measure is comparable to the state's peers. Uncompensated care is one driver of cost shift. Nationally uncompensated care as a percentage of total expenses is 5-6 percent, and has been since 2000. In dollar terms, however, uncompensated care costs continue to rise and now stand at over \$28.0 billion.

### **Aging Population**

Demand for health services will continue to grow rapidly as the "Baby Boomer" generation moves into retirement later this decade, placing further strain on health care providers and available resources. The Delaware Population Consortium (2007) projects an increase in the 65 plus population by 123,000 people or 106% between 2005-2030. By 2030, almost 238,000 people will be 65 and older and the population of the "oldest of the old", age 85 and older, will more than double to almost 31,000 people. Not only will there be more older people, but with advancements in health care, people are also living longer. This aging of the Delaware population fosters greater demand for health care services in the future, and is consistent with rising health care expenditures forecast over the next twenty years.

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<sup>17</sup> *Total Cost of Health Care in Delaware.* (2007). Simon Condliffe and Edward C. Ratledge. CADSR, University of Delaware.

### **Prescription Drugs**

The drug sector is the fastest growing source of spending on health care and shows no sign of abating. Between 1997 and 2002, the number of prescriptions purchased increased 68 percent (from 1.9 billion to 3.2 billion.) The average number of prescriptions per person increased from 7.3 to 11.1. Several factors foster this growth. For example, the U.S. Food and Drug Administration (FDA) accelerated its approval process of new drugs and the drug industry increased its promotion of these drugs with direct-to-consumer advertising. The outlook for drug expenditures is for continued strong growth.

Rising drug costs are exerting pressure on employers and health plan providers alike. Prescription drug costs are the most rapidly increasing expense for employer-based insurance, representing 40% of the premium increase from 1998-1999. These costs lead health plan providers to limit drug coverage and/or demand higher premiums from employers. Employers, in turn, pass on the costs to employees by asking for greater health care enrollment fees, or by opting for higher co-payment plans. In either case, consumer spending on health care increases.

It is important to note, however, that additional spending on prescription drugs does not necessarily translate into additional dollars spent on total health care. For some ailments, drugs are a substitute for more costly procedures or treatments (depression is one example). Therefore, some breakthroughs in drug therapies may reflect a switch away from traditional treatment techniques.

# Health Care – Quality

## **Health Indicators**

### *Delaware Vital Statistics Annual Report (DVSAR) 2006*

One way to monitor health care quality in Delaware is through public health indicators. According to Delaware Vital Statistics Annual Report (DVSAR) 2006 (the latest year available at time of printing), the first and second leading causes of death continue to be heart disease and cancer, at 26 percent and 25 percent respectively, accounting for more than half of all deaths. Chronic respiratory disease accounts for 5 percent, followed by stroke (5 percent), accidents (4.5 percent) and diabetes (3 percent). The “all other causes” category represents the remaining almost 32 percent.

For the same time period, the number of infants dying within the first year of life was the highest it has been in 10 years. Though Delaware’s infant mortality rate was significantly higher than the national rate throughout most of the 1980s, Delaware then followed the nation’s downward trend to a point where the U.S. and Delaware rates became almost identical. The 1994-1998 period saw a reversal of Delaware’s declining trend, and the infant mortality rate has risen over every 5-year period since. For the most recent period, the United Health Foundation’s America’s Health Rankings (2008) statistics show a rate of 9.0 infant deaths per 1,000 births, significantly higher than the U.S. rate of 6.5. For the same time period, Delaware’s age adjusted cancer mortality and HIV death rate were significantly higher than the U.S. rate. On the other hand, Delaware’s age-adjusted stroke mortality rate was significantly lower than the U.S. rate.

### ***America’s Health: State Health Rankings – 2008 Edition***

Overall, according to *America’s Health: State Health Rankings - 2008 Edition* Delaware ranks 35<sup>th</sup>; it was 30<sup>th</sup> in 2006. The report, the 20<sup>th</sup> in a series, is produced by the United Health Foundation in partnership with the American Public Health Association and the Partnership for Prevention. The study methodology weighs the contributions of various factors, including a number of risk factors -- such as the presence of health insurance and the prevalence of smoking -- and health outcomes, such as cancer deaths and heart deaths.

According to the report, Delaware’s strengths include high immunization coverage with 81.8 percent of children ages 19 to 35 months receiving complete immunizations, and a low percentage of children in poverty. Delaware is ranked 18<sup>th</sup> in the nation in per capita public health funding at \$89 per person.

Challenges include a high incidence of infectious disease at 24.6 cases per 100,000 population (45<sup>th</sup> in the nation), a high violent crime rate (increased from 682 to 689 offenses per 100,000 population), and a high prevalence of binge drinking at 18.8 percent of the population. Another challenge is the rising rate of obesity: in the past year, the prevalence of obesity increased by nine percent, from 26 percent in 2007 to 28.2 percent of the population in 2008. Also, Delaware is ranked 46<sup>th</sup> in the nation, with the 5<sup>th</sup> highest infant mortality rate.

## **Health Disparities**

The issue of racial and ethnic health disparities is a concern because of its impact on length and quality of life and the relationship with cost and quality of health care. While the causes

are complex and difficult to identify, disparities may be attributed to health care delivery, socioeconomic status, culture, language, environment, genetics, and personal behavior.

According to the DAVSR 2006 Report<sup>18</sup>, life expectancy rates for babies born in 2006 exemplify the fact that health disparities exist in Delaware:

White males, 76.4 years	Black males, 71.4 years
White females, 81.7 years	Black females 77.8 years

The differences in life expectancy are directly related to differences in mortality for a wide range of diseases. For example, black Delawareans are about 20 percent more likely than whites to die from heart disease and twice as likely to die of complications from diabetes as white Delawareans.

HIV/AIDS mortality has also disproportionately affected Delaware's black population. The 2002-2006 mortality rate of 30.74 deaths per 100,000 was seventeen times higher than the rates for whites. In the 2002-2006 time period blacks accounted for 77 percent of all deaths due to HIV/AIDS. According to the 2008 Delaware Racial and Ethnic Disparities Health Status Report Card, location also appears to be an issue: 72 percent of HIV cases are found in New Castle County and 44.4 percent of HIV cases are in the areas that tend to be linked to the city of Wilmington.

Another clear example of disparities is found in the infant mortality rates in Delaware from 2002-2006. Overall, the rate in DE for blacks was 16.1 percent, compared to 6.4 percent for whites and 7 percent for Hispanics. Delaware also performs worse than the nation on infant mortality rates: 13.9 percent for blacks in the U.S. compared to 5.7 percent for whites.

In 2005, Governor Minner, under Executive Order #68, convened a Task Force (TF) to examine strategies to address racial and ethnic health disparities in Delaware. The TF was to "develop broad-based recommendations for the reduction of health disparities in Delaware, which are based upon scientific evidence, defined partnerships, expected contributions, timelines, review and evaluation."<sup>19</sup> The Commission was represented on the TF by its Chair, Lt. Governor Carney. The TF was assigned with the following tasks:

Recommendations from the Task Force report issued in June 2007 related to Health Care Commission initiatives are:

1. Recommend the Delaware Health Information Network (DHIN) support the collection of chronic disease health indicators (minimum data elements) as part of standard provider reporting.
  - Identify which minimum data elements should be collected on clients including indicators for mental illness, diabetes, cardiovascular illness, stroke, asthma, cancer and other diseases as identified.
  - Recommend that relevant agencies participate in DHIN implementation.

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<sup>18</sup> Due to data limitations, statistics in the DAVSR 2006 are only presented for black and white populations.

<sup>19</sup> Executive Order Number 68:

<http://www.state.de.us/governor/orders/webexecorder68.shtml#TopOfPage>

2. Diversify the health workforce in Delaware:

- Support an initiative of the Health Care Commission and the Division of Professional Regulation to explore the routine collection of certain HIPAA-compliant data on race/ethnicity/language from health professionals through the licensure renewal process.
- Support budgetary requests for additional funding for the State Loan Repayment Program (through the Health Care Commission) to recruit a racially/ethnically diverse pool of providers to practice in underserved areas of the state.
- Support increased funding to encourage DIDER and DIMER to begin to establish relationships with Historically Black Colleges.

# Targeted Strategies to Promote Access to Affordable, Quality Health Care in Delaware

## 2009 Strategic Plan –

The Commission focuses activity on five (5) major areas to promote and improve access to affordable, quality health care:

- 1. Uninsured Action Plan**
- 2. Information & Technology**
- 3. Health Professional Workforce Development**
- 4. Research & Policy Development**
- 5. Specific Health Care Issues & Affiliated Groups**



## Uninsured Action Plan – State Planning Program

**Purpose-** the State Planning Program, launched in 2001 after securing funding from the U.S. Health Resources and Services Administration (HRSA), permits continued analysis of health insurance coverage options for Delaware. Over the course of the Planning Grant period the Commission rigorously reviewed and analyzed over twenty short term and long term options. In 2007, Planning Grant funds expired, but after extensive consideration, two strategies have been analyzed and the Commission concluded that these were most appropriate for Delaware moving forward:

### **Preserve and Expand Coverage-**

The Commission has defined a two-pronged strategy addressing the issue of access to health care: preservation of existing insurance coverage; and expansion of insurance coverage to the uninsured.

#### Preservation:

Small Group Insurance Reforms (Delaware Code Title 18, Chapter 72)  
Small Group Health Insurance Pooling  
Greenaght® Downstate Insurance Initiative

#### Expansion

S-CHIP – maximize enrollment of eligible children  
Community Health Center Marketing

#### Universal Coverage:

Single-Payer and Building Block Approaches - the Commission's long-term coverage strategy is the analysis of universal insurance coverage systems for Delaware. In 2007 a contract was signed with Jonathan Gruber, PhD to conduct econometric simulation and analysis of two models: traditional single-payer and a "building blocks" model that makes use of existing systems based on reforms implemented in the state of Massachusetts. Results from this study are due to the Commission and will require further discussion and refinement of the findings in 2009.

### **PRESERVE: SMALL GROUP HEALTH INSURANCE REFORMS**

In 2006 a report prepared by Elliott Wicks, PhD, of the Economic and Social Research Institute, was submitted to the Small Business Health Insurance Committee for consideration. The Committee reviewed the materials and presented recommendations to the Health Care Commission, adopted in May 2006, that seek to reform current small group insurance regulations in Chapter 72, Title 18. The goal is to achieve better stability, predictability and enforcement of insurance premiums in the small group market, primarily affecting small businesses and small not-for-profit organizations.

One overall problem uncovered during the most recent analysis was that the current law is complicated, difficult to understand and difficult to enforce. Specific problems identified include the following:

**1. Problem: Rate Variation** – High risk groups pay much more than low risk groups. Generally the variation is five times more, but could be as much as 9 times more. (9:1)

**Recommendation:** Compress the allowable rate variation, phasing in a reduction over a four year period. The initial allowable rate variation would be 5:1, and would decrease by .5 annually until it reaches 3:1. The result of compressing the rates is that some very low risk groups may experience increases, while high risk groups experience some rate reduction. The gradual decrease will mitigate any potential “shock” of these rate changes.

**2. Problem: Multiple rating factors** – The current law includes seven factors that can be considered when determining rates:

Age	Health-related factors	Group size	Class of business
Industry	Location/geography	Gender	

Multiple factors give more leeway in determining rates and negate the intent of making rates more predictable and stable.

**Recommendation:** Reduce the number of allowable rating factors to three:

Age  
Health Status  
Group Size

All three are legitimate predictors of risk, and the reduction will serve to keep rates compressed and reduce variation.

**3. Problem: Groups of One** – Many states with similar laws define small groups as those ranging from 2 – 50. Delaware opted to include “groups” of one to allow sole proprietors the advantages of purchasing health insurance in the group market, rather than the individual market. Interviews revealed that this allows an individual the option of purchasing insurance in either the individual or group market, depending upon which is more advantageous. Cost for a group of one is extremely difficult to predict, since only one adverse event will raise costs and there is nowhere to spread the risk. However, since the purchase of insurance in the group market by groups of one has been permitted for several years, the committee believed it imprudent to prohibit it.

**Recommendation:** Retain the current definition of 1-50, but allow a one point higher rate variation than groups of 2-50. Hence, the initial rate variation for groups of one would be 6:1 and would gradually reduce to 4:1.

**4. Problem: Rate stability** – As group characteristics changed from low risk to high risk, premiums were subject to very large increases. In addition to compressing the allowable rate variation another mechanism to make rates more stable from year to year needs to be implemented.

**Recommendation:** Limit the amount of increases due to changes in health status (one of the allowable rating factors) to 15 percent.

### **5. Potential Problem: “Virtual” self-insurance with stop loss coverage**

Although not documented in Delaware, other states report fears that those purchasing insurance in the small group market could avoid the laws by paying out of pocket for all services up to a designated limit (example, the first \$10,000 of cost) and purchasing stop loss or reinsurance at a very low “attachment point” – in the current example, \$10,000. Unlike large firms that typically do self-insure, small firms are not well equipped to act as self-insureds. This is not a typical scenario in Delaware, but one which the Committee recommends should be avoided.

**Recommendation:** Prohibit the sale of stop loss insurance in the small group market.

Legislation based on these recommendations has been drafted and will be circulated to the Commission’s Small Business Committee for final review.

## **2009 ACTION- Small Group Health Insurance Reforms**

### **1. Introduce legislation to implement recommendations in January 2009.**

<b>PRESERVE: SMALL GROUP INSURANCE POOLING</b>
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Another recommendation from the Commission’s Small Business Health Insurance Committee is the creation of a small group health insurance pool. The Commission will cooperate and work with the State Insurance Department in these and other endeavors. Rising health care costs and insurance premiums have made it difficult for some businesses and non-profit organizations to afford coverage for their employees. High costs are often passed on to low-income employees, and as a result, coverage may be dropped. The goal of a purchasing pool is to assist small group employers with purchasing health insurance for their employees. In 2006 and 2007-2008 two bills were introduced but did not pass into law: SB 146 and SB 6, respectively.

In June 2007, a House Resolution (HR 38) passed, establishing a Health Insurance Pool Task Force, for which the Commission provided co- staffing responsibilities. Two Task Force meetings were held, one of which Dr. Elliot Wicks of Health Management Associates was asked to make a presentation on the merits and deficiencies of pooling and the experience that other states have had with similar approaches. In his testimony before the task force, Dr. Wicks stated that healthcare purchasing pools that have been established elsewhere have suffered from a phenomenon known as “adverse selection”. Pools initially attract people from all risk groups, but the lower-risk participants soon learn they can purchase coverage individually for less than the rate offered to the pool as a whole. As these individuals leave, the premiums for the remainder of the group escalate, encouraging more participants to exit. Ultimately, the pool is left with high-risk individuals who remain only because they have few other options. Dr. Wicks said pools to insure these high-risk individuals have merit, but because of the high premiums they must receive significant state subsidies to remain viable. Recommendations were submitted in March 2008.

Other structural issues important for pools to succeed include assuring that the same rating rules apply for plans sold inside the pool as well as outside of the pool.

## **2009 ACTION- Small Group Insurance Pooling**

- 1. Continue to cooperate and work with the State Insurance Department in these and other endeavors.**

<b>PRESERVE: CREENAGHT® – DOWNSTATE INSURANCE INITIATIVE</b>
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While the Commission continues to address issues related to the small group health insurance market, a consortium of Sussex County businesses and local chambers of commerce have developed a health insurance plan targeting small employers and individuals. The benefit plans are based on a disease management model with an emphasis on individual health management responsibility and accountability. Clients receive financial incentives in the form of reduced cost deductibles if they participate in screenings for health risk factors and, if warranted, participate in disease management programs to improve individual health outcomes.

The Commission provided support early-on with the provision of an initial analysis of the disease burden in the target population. This product serves as a useful test of whether a disease management model can reduce costs for small business and improve health insurance coverage. More information can be found at: <http://creenaght.com/index.html>

## **2009ACTION- Creenaght® – Downstate Insurance Initiative**

- 1. Continue to follow the implementation and progress of this program and invite key stakeholders to update the Commission in the spring of 2009.**

<b>EXPAND: S-CHIP (Delaware Healthy Children Program)</b>
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The second part of the Commission's two-pronged, short-term strategy is the expansion of insurance coverage. In 2006 a strategy was considered to extend coverage to parents of children who qualify for the S-CHIP program, a coverage initiative under the Delaware Healthy Children Program. This approach would create seamless family coverage for families at less than 200 percent of the Federal Poverty Level. However, given the environment within the federal government in 2007-2008, including difficulty achieving program re-authorization and a propensity to deny states' requests for expansion waivers, it was agreed that this approach was not the most realistic at that point in time. It is unclear at this time whether this should be revisited in 2009-2010.

In 2008 and through 2009 the Commission will focus on maximizing enrollment of additional children that are eligible but not enrolled in the program (approximately 8,840 children).

## **2009 ACTION- S-CHIP- Maximize Enrollment**

- 1. Evaluate the effectiveness of and actively participate in outreach strategies (i.e. Health Access America, Covering Kids & Families, Healthy Delawareans Today &**

**Tomorrow, and interagency collaboration) in Delaware to increase enrollment in S-CHIP -- registering eligible, yet non-enrolled children.**

#### **EXPAND: COMMUNITY HEALTH CENTER MARKETING**

The Community Healthcare Access Program (CHAP) and the State Planning Program compliment one another as ways to support the state safety net, improve access to care and provide seamless coverage to Delawareans. In 2006 a need was identified to assist some of the state's community health centers in attaining their outreach goals and operating at full capacity. These health centers play an integral part in maintaining the success of CHAP and informing program designs as well as serving patients in underserved areas of the state.

In 2007, an analysis was conducted by John Snow, Inc. (JSI) to determine how and why various populations access health services, particularly in community health centers. Initial efforts focused on the Henrietta Johnson Medical Center (HJMC) in Wilmington. The primary goal was to understand the perceptions, attitudes, level of satisfaction/awareness of individuals who: 1) currently receive health care services at a federally qualified health center (FQHC); 2) have received services in the past; and 3) who have never received services at a FQHC. The final deliverable from JSI included a report and a "tool kit" that would allow other sites to replicate the study.

In 2008, through the Mid Atlantic-Association of Community Health Centers (MACHC) two other FQHC's in Delaware, La Red Health Center and Delmarva Rural Ministries, replicated the HJMC study. In order to preserve credibility of the process and similarity of the data, the Commission arranged for JSI to train the FQHC's on how to conduct the study. Subsequently, the FQHC's submitted their raw data to JSI for analysis. The costs for the data analysis were shared between the Commission and the Division of Public Health.

#### **2009 ACTION- Community Health Center Marketing**

- 1. Examine key findings from the Delaware Federally Qualified Health Center (FQHC) Research Study and analysis conducted by John Snow, Inc. (JSI).**
- 2. Collaborate with FQHC's and the Division of Public Health to develop and implement recommendations from JSI analysis (i.e. targeted marketing strategies; operational and performance improvement efforts; improve access/reduce barriers to care).**

#### **EXPAND: UNIVERSAL COVERAGE**

*SINGLE PAYER APPROACH* - This long-term coverage strategy includes an examination of the feasibility of implementing a single-payer health care financing system in Delaware to achieve universal coverage. A Phase I study focused on feasibility was completed in 2007. It included a framework of basic system design, which will be used as a basis for modeling

the financing of such a system. A detailed analysis of design and implementation strategies for a single payer system, is nearly complete.

**BUILDING BLOCK APPROACH** - This strategy toward achieving universal coverage would build upon and make use of existing systems and coverage programs in Delaware, such as Medicaid, S-CHIP, CHAP, etc. A specific review and analysis of other state health reforms such as those adopted in Vermont and Massachusetts and proposed in California were included in the project.

In June 2007 the Health Care Commission released a Request for Proposals to conduct econometric simulation and analysis of options to achieve universal health insurance coverage in Delaware to understand the financial impacts of the respective strategies, *single payer* and *building block* approaches.

Three proposals were received and in September 2007 the Commission awarded the contract to Jonathan Gruber, PhD from the Massachusetts Institute of Technology. A final report will be completed in 2009.

### **2009 ACTION- Universal Coverage**

- 1. Complete micro-simulation modeling of approaches to universal coverage to describe costs and financing more precisely (Single Payer and Building Blocks).**
- 2. Invite Commissioners and members of the Small Business Insurance Committee to participate in universal coverage activities.**
- 3. Receive and respond to modeling results, final analysis report and offer objective feedback.**
- 4. Engage legislators and administration in modeling activities.**

## **Uninsured Action Plan – Community Healthcare Access Program (CHAP)**

The Community Healthcare Access Program (CHAP) helps find low-cost health care services for uninsured people with incomes below 200 percent of the federal poverty level (= \$42,400 for a family of four). A network of community care coordinators links uninsured people with health homes or, if eligible, with public coverage programs like Medicaid.

Medical services for CHAP enrollees are provided through community hospitals, community health centers, and a network of over 500 private physicians who participate in the Voluntary Initiative Program (VIP). CHAP, which began enrolling patients in June 2001, was initially funded through a federal grant from the Health Resources and Services Administration (HRSA). Today, the program is funded entirely by revenue from the state's Master Tobacco Settlement Agreement, distributed by the Delaware Health Fund Advisory Committee.

Participating hospitals and health centers include: Beebe Medical Center, Christiana Care Health Services (Newark and Wilmington locations), Claymont Family Health Services,

Westside Family Health Care, Henrietta Johnson Medical Center, Delmarva Rural Ministries, Nanticoke Health Services and La Red Health Clinic.

**CHAP Purpose-** Provide medical homes for the low income uninsured to improve quality and reduce inappropriate hospital emergency department visits and hospitalizations.

**CHAP Goals-**

- Provide uninsured Delawareans with a regular source of primary care and easy access to other health services
- Increase enrollment in other state or federal medical coverage programs if eligible
- Improve the coordinated use of existing programs and resources
- Ensure that the most vulnerable populations are equipped with better health system navigation skills and better understanding of the importance of prevention
- Improve health status with a health risk assessment and disease management component that identifies and focuses on high-risk and high-need patients

According to the most recent report of the uninsured in Delaware, about 20,720 people (18 percent of the uninsured population) are eligible for CHAP and make up the program's target population. Since the program's inception, a total of 26,251 applications for initial enrollment were received and 17,892 people were enrolled at some point in CHAP. An additional 3,202 applicants were identified as eligible for Medicaid and 103 were referred to the Veteran's Administration (VA). As of November 30, 2008, 5,467 people were actively enrolled and receiving services through the program.

A total of 7,028 applicants were found not eligible for a variety of reasons, such as they were income ineligible or they may have obtained other insurance (i.e. 3,202 of them were eligible for Medicaid).

Currently, CHAP eligibility is limited to uninsured Delawareans at or below 200 percent of the Federal Poverty Level (FPL). However, opportunities for CHAP to possibly expand eligibility to promote coordination with the Delaware Health Resources Board (HRB) charity care policy implementation and enforcement are being explored. Currently, the HRB defines "charity" as 350 percent FPL. A new contract between the Health Care Commission and the Center for Applied Demography and Survey Research (CADSR), at the University of Delaware will reveal more details about target populations and the possible implications of program expansion. (More information is available on page 43 of this report.)

In 2007 AstraZeneca (AZ), a Delaware based pharmaceutical company, announced the start of a new initiative called Healthy Delawareans Today and Tomorrow. Through this partnership with Delaware's public and private sector health care community, AZ provided \$500,000 to augment CHAP by supporting "health navigators" at community health centers. The health navigators will work as case managers to help the uninsured access healthcare facilities and services. Also, as a further step toward harmonization, AZ will accept CHAP reporting mechanisms used to collect data and reported by the FQHCs as the same reporting mechanism for their investment. In 2009, the CHAP Workgroup will actively strive for increased coordination with AZ for an ongoing partnership to enhance CHAP.

### Evaluation

In 2006, a new component of CHAP was implemented: the administration of a health risk assessment (HRA) to all new enrollees to identified high risk patients. This process helps to identify enrollees who need more care and are considered “high risk”, including clients who smoke, are over the age of 50 years, and/or who have diabetes, hypertension, or asthma. From May 2006 through May 2007, a follow up assessment was conducted to analyze baseline data for enrollees that participated a full-year. Results indicate that CHAP enrolls a high percent of people with high risk conditions and chronic illness. The evaluation also revealed that high risk enrollees are seeing health improvements in most areas. In 2009, evaluation of the health status of CHAP enrollees will continue, and a new evaluation dimension will be on evaluating birth outcomes and prenatal care. HRA surveys will be administered in a limited way in 2009 to identify high risk enrollees and to measure quality of care they receive after being enrolled. Furthermore, alternate data sources for program evaluation will be explored.

### Program Successes

To determine if CHAP is meeting its intended goals, the Commission conducts ongoing evaluation of the program. Some findings are summarized below.

Health status and quality of care, as measured by preventive care, has improved.

- CHAP enrollees have an increased rate of preventive health screenings, such as mammograms, pap smears, cholesterol tests and flu shots.

Emergency department visits have been reduced.

- CHAP patients visit hospital emergency departments three times less than other uninsured individuals.

Uninsured people with medical homes have increased.

- As of November 30, 2008, almost 18,000 uninsured patients have been enrolled and received care at a participating health home or private practitioner since the program’s inception.

The number of volunteer physicians participating in VIP is increasing:

- Fall 2003 – 334 physicians (20 percent of practicing physicians)
- Fall 2007 – 500 physicians (28 percent of practicing physicians)
- Fall 2008 – 511 physicians (29 percent of practicing physicians)

### Outreach

Currently CHAP has two types of outreach partners; hospitals and non-profit organizations who can reach the target population. Hospitals have the unique means to identify potential CHAP enrollees through their direct daily operation and community programming. Similarly, some non-profit organizations can help find and assist CHAP enrollees. A challenge in 2007-08 was to evaluate the effectiveness of the program’s outreach strategies by focusing on enrollment increases of eligible participants in targeted areas. While the community outreach vendors are broadly disseminating information about CHAP, the resulting program enrollees do not necessarily know the outreach vendor by name to credit for raising their awareness and/or evoking their application. A strategy was implemented in 2008 to improve



outreach evaluation by consolidating contracts, establishing performance measures, standardizing activities and providing CHAP with documentation of outcomes.

**2009 ACTION- Community Healthcare Access Program (CHAP)**

**1. Implement the following components of a CHAP Workgroup Action Plan:**

- **Engage with AstraZeneca and recommend strategies for better coordination.**
- **Continue to examine ways to expand primary care and prevention by building on the CHAP network.**
- **Continue to examine opportunities for collaboration with the Health Resources Board.**
- **Identify opportunities to blend Screening For Life Program (SFL) & Community Healthcare Access Program (CHAP) to:**
  - **Improve outreach**
  - **Gain greater administrative efficiencies**
  - **Track movement in and out of program as well as patient outcomes**
  - **Reduce eligibility and enrollment system barriers**
  - **Improve services to patients**
- **Continue program evaluation (i.e. quality of care; access to services; outreach and enrollment); receive a report and determine next steps.**

## Information & Technology – Delaware Health Information Network (DHIN)

The implementation of health information technology has emerged as a national priority, and Delaware is the leader in the development of a statewide clinical information exchange. Access to accurate and up-to-date patient health information will improve the delivery of care and reduce the duplication of procedures, thus helping to control health care costs. No longer will doctors have to rely on patients' memories for their medical history or contact multiple medical offices or labs and wait days for information to arrive. The intent of the DHIN is to provide secure, fast, and reliable exchange of health information among the many health care providers treating patients in the State of Delaware. The DHIN will improve the quality of care in Delaware and reduce costs associated with a reduction in medical errors. DHIN continues to enjoy strong support from key stakeholders, including Delaware's federal Congressional delegation.

### **DHIN Purpose**

The organizational structure for the Delaware Health Information Network (DHIN) was established by the Delaware General Assembly in 1997 as a public instrumentality of the State, which functions under the direction of the Health Care Commission. The DHIN was designed as a public-private partnership, which provides the organizational infrastructure to support the implementation of a clinical information sharing network. The DHIN has served as the incubator organization for the health information exchange project since its inception. While DHIN operates under the auspices of the Health Care Commission, it is guided by the DHIN Board of Directors, Executive Committee, Consumer Advisory Committee, Project Management Committee, Health Information Management Systems (HIMS) Committee and a Clinical Advisory Group. The DHIN statutory purpose includes:

- Advance the creation of a statewide health information and electronic data interchange network for public and private use.
- Serve as a public-private partnership for the benefit of all citizens of Delaware
- Address Delaware's need for timely, reliable and relevant health care information
- Reduce participants' administrative billing and data collection costs
- Ensure the privacy of patient health care information

### **DHIN Project:**

DHIN is a secure, reliable communication system that is available to healthcare providers throughout Delaware. Through a combination of the latest in technology and well-designed security practices, this system makes it possible for physicians, hospitals and labs to deliver and access critical health information to ensure better healthcare for patients in Delaware. The beneficiaries of DHIN include patients, health care providers, insurers/health plans, and employers.

## **DHIN Planning**

In May 2005, DHIN began a planning process to define the system requirements for a clinical health information exchange network. An environmental analysis provided the basis for understanding the current technical capabilities of stakeholder organizations as well as their functional needs for DHIN.

In addition to the technical and functional requirements of the system, a cost-benefit analysis was conducted to better understand the cost of building the system and the benefits to the stakeholder groups, including: hospitals and health systems, health plans, employers and State government (through Medicaid and state employee's health plan savings as well as streamlined bioterrorism and public health reporting).

In February 2006, a Request for Proposals (RFP) including all requirements for the DHIN was completed. In March 2006, the RFP was published to solicit bids from a qualified contractor to design, develop and implement a clinical information exchange network in Delaware. Six bidders responded to the RFP. After careful review by a stakeholder-wide evaluation committee as well as live test demonstrations from the top three bidders, DHIN negotiated and signed a contract with Medicity, Inc. to implement the system. Medicity is teaming with Perot Systems to deliver specific infrastructure portions of the DHIN project. Perot Systems provides data center services, technical and provider help desks as well as on-site customer service and system implementation.

In June 2006, an RFP for Quality Assurance Monitoring was released and John Snow, Inc (JSI) was selected as the vendor. The purpose of this contract is to help ensure the DHIN project comes in on-time, on-budget and within scope.

## **DHIN Partners**

Data senders - those organizations that provide diagnostic testing, radiology and/or in-patient services based on practitioner orders - include: Bayhealth Medical Center, Beebe Medical Center, Christiana Care Health System and LabCorp. In 2009, we anticipate connecting additional data senders. As of December 2008, Data receivers – those who order diagnostic tests, radiology and/or admit patients for in-patient care – include 93 physician practices (593 physicians some with multiple practices are enrolled) with statewide representation and varying size, specialties, and levels of technical sophistication. Other key partners include Blue Cross Blue Shield of Delaware and Delaware Physicians Care, Inc. (Medicaid Managed Care).

## **Phase 1: Results Delivery**

The first phase of the project was successfully implemented in March 2007. Currently DHIN provides a streamlined results distribution system that delivers approximately 80 percent of lab tests and hospital admissions in the state. Health care providers receive lab, radiology and other test results via telephone, fax, courier, and in some cases through a web portal that the provider must sign into and query for his/her patient's test results. DHIN allows the provider to decide in what format he/she wants to receive all test results and delivers those results to the provider in real-time based on their chosen method. Providers also receive alerts when a result is outside normal limits. In most cases, there is little to no added investment to the provider and the result is a more efficient, cost-effective and streamlined

process for the practice. Those practices that have Internet access may choose to have results delivered to a secure mailbox where they can track their patients' test results and make referrals to other providers using the DHIN. Practices with electronic medical records can have results delivered directly to the patient's electronic record in a secure manner.

### **Where does the information go?**

All of the clinical results sent by each sending organization are stored in a segregated database where only the sender, the recipient, and certified DHIN database administrators are authorized to access it. The benefits to this approach include:

1. The provider can simply query DHIN to get another copy if he/she cannot locate the original rather than having to call the sender to request another report.
2. It permits the patient's physician to view all test results in one location to provide historical context if the information in the paper file is not conveniently available.
3. It permits the patient's physician to authorize access to a specialist at the time of referral.

### **Phase 2: Patient Record Inquiry**

In Phase 2 of system implementation, participating providers will be able to query the DHIN for patient record history once an authorized patient-provider relationship has been established in the system. (This process will likely require patient consent based on policies to be developed in collaboration with the DHIN Consumer Advisory Committee). For example, when a patient is new to a practice, the provider may query the DHIN to better understand the patient's history and therefore provide more informed treatment. Information which may be available on a patient could include medications, allergies, test results, and hospitalizations. In another scenario, if a patient presents in the emergency room, providers there would be able to learn about the person's health history to provide better treatment. Should the patient not be able to speak for him/herself or remember important details in a traumatic situation (e.g., medications and allergies); information obtained from the DHIN may be the difference between life and death. Phase 2 is set to go-live in 2009 and will also include a patient centric record history, public health reporting, transcribed reports, consumer participation via a patient portal, electronic order entry and the addition of new data senders and electronic medical record (EMR) users.

### **Added Functionality**

DHIN will add onto the functionality in Phases 1 and 2 based on available funding and stakeholder interest. Added functionality may include: electronic order entry, electronic prescribing, a patient portal with personal health record access, secure provider-patient electronic communication, benefits eligibility verification, population health, disease management, and electronic claims submission.

### **Funding**

In October 2004, DHIN was awarded \$700,000 through the Federal budget. These funds are administered through a contract with the U.S. Agency for Healthcare Research and Quality (AHRQ). With support from Delaware's Congressional Delegation and through a successful

RFP response, DHIN was able to leverage an additional \$4.0 million from AHRQ totaling \$4.7 million over a five year period (ending September 2010).

In FY07 and FY08, DHIN was awarded \$2.0 million and \$3.0 million respectively from the Delaware General Assembly through the Bond and Capital Improvements budget ("Bond Bill"). It is the basis on which DHIN leverages federal and private funding to develop and implement phases of the system as work toward an operational/sustainability plan develops. In FY09, \$1.5M was appropriated in the Bond and Capital Improvement Act. DHIN is requesting \$2.5 million in the capital budget for FY10, which is the amount needed to implement the final year of new functionality. These funds will be matched (and likely exceed) by private sector funding; but are nonetheless are vitally important to moving DHIN toward its sustainability model.

In 2007, DHIN responded to a Request for Proposals (RFP) from the U.S. Department of Health and Human Services, Office of the National Coordinator for Health Information Technology for the National Health Information Network (NHIN) entitled *Nationwide Health Information Network Trial Implementation*. DHIN was one of nine states selected to implement NHIN use cases statewide and connect with other NHIN prototype sites. In 2008, work began to implement two use cases and demonstrate interoperability with other NHIN sites. Use cases currently under negotiation with NHIN are: biosurveillance/public health reporting, medication management, emergency responders, and lab reporting. NHIN funding is helping to support real time delivery of reportable disease data from hospital labs to the Division of Public Health through the DHIN, a valuable tool to monitor and manage potential disease outbreaks in Delaware. Without DHIN, these outbreaks might be identified in weeks; with DHIN, these outbreaks are identified in days or even hours and can result in reduced illness and days of work lost.

On June 16, 2008 a press conference was held in Delaware with Sen. Carper, Lt. Governor Carney and the Deputy Secretary for the U.S. Department of Health and Human Services, announcing the award of \$29 million to Delaware that will go directly to physicians to encourage Electronic Medical Record (EMR) adoption. This received national press and has the potential to bring \$29 million dollars to Delaware physicians over a five year period. DHIN is the sole reason that this funding is available for Delaware physicians. Not only does this funding directly benefit Delaware physicians, it also benefits the state as an insurer and payer of health care. EMRs have been proven to improve physician compliance with clinical guidelines, reduce the potential for adverse health effects from drug interactions and more. This presents significant potential for cost savings as well as improved health outcomes for Delawareans. EMRs that are connected to DHIN exponentially create cost containment benefits.

### **Privacy and Security are Paramount**

All access beyond the initial ordering physician will be subject to rigorous debate before permission will be granted. DHIN has state of the art security and disaster recovery protocols. Every transaction is logged and all access through patient record inquiry will be audited, including who viewed a given patient's information and when. The secure databases are systematically scanned for quality control purposes and are fully HIPAA compliant. Security protocols require users to be authorized with regular password reset intervals.

### **Project Status**

The DHIN project is on track to meet the “go-live” target for Phase 2, patient record inquiry, in 2009. DHIN will continue to recruit and enroll additional physician users throughout the state. Current users include 93 physician practices (some with multiple locations), which account for over 593 doctors in the state, and a total of 1,780 users. In 2008, Delaware’s four federally qualified health centers (La Red Health Center, Westside Health Services, Delmarva Rural Ministries and Henrietta Johnson Medical Center) connected to DHIN.

In 2009, DHIN sustainability planning will be critical to transition from building functionality (the capital phase) to its self-sustaining model (operational phase) in FY10. This model is based on the premise that those who benefit from the system pay for the system. DHIN is currently in negotiations with the State’s largest health plans to develop a financing model that includes long-term participation in support of patient record inquiry and medication history functions.

### **2009 ACTION- Delaware Health Information Network (DHIN)**

- 1. Stay informed and support DHIN development and implementation.**
- 2. Support continued State funding with a request for funds in Fiscal Year 2010.**
- 3. Continue administrative support.**
- 4. Fill Board vacancies that are Health Care Commission appointments, as appropriate.**
- 5. Actively engage in discussions and in the development of a sustainability plan.**

# Health Professional Workforce Development –

## **Delaware Institute of Medical Education and Research (DIMER)<sup>20</sup>**

Created in 1969 as a cost effective alternative to establishing a medical school in Delaware, DIMER provides enhanced opportunities for Delaware residents to obtain a medical education.

A key function of DIMER is to provide financial support for Jefferson Medical College (JMC) and Philadelphia College of Osteopathic Medicine (PCOM) in exchange for reserved admission slots for Delawareans, twenty at JMC and five at PCOM annually. The relationship with JMC was established in 1969. The relationship with PCOM was established in 1999. In cooperation with the Delaware Higher Education Commission, the program also provides scholarships and tuition supplements for participating students at both schools, located in Philadelphia, Pennsylvania.

### **Issues:**

Delaware's relationship with JMC and PCOM continues to thrive and Delaware derives significant benefits from the relationships. Both schools have consistently accepted the requisite number of Delaware students, more some years, and the quality of medical education is high. Additionally, the co-administration of scholarships between the Commission and the Higher Education Commission for DIMER students is smooth.

The DIMER program successfully increases the likelihood that Delaware students will be accepted to medical schools. Through DIMER, the odds of a Delaware resident being accepted into Jefferson are about one-in-four. The odds of someone from another state being accepted, without a cooperative agreement such as DIMER, are about one in 50. PCOM matriculations are on target – 7 students were accepted and 4 matriculated. At JMC matriculations increased; 30 students were accepted and 22 matriculated, higher than in 2007 when only 20 students matriculated.

Since JMC and PCOM are private colleges, the high tuition rates may be a deterrent to some students. Tuition and fees for the 2008-09 school year for a non-resident is \$43,033 at JMC and \$37,509 at PCOM.<sup>21</sup> Although DIMER provides some funding through scholarships and tuition stipends, the high tuition and corresponding prospect of having significant education debt upon graduation are regarded as barriers to recruiting key target populations.

Geographical, racial and ethnic diversity of participating students remains a challenge. A review of the admission statistics show a lower number of Delaware minority students and residents of Kent and Sussex Counties apply than residents of more urban New Castle County. It is an ongoing challenge to recruit students of color (particularly black and Hispanic) and rural residents to medical school. In 2008, Commission staff presented information on the DIMER and DIDER enhanced educational opportunities to the Delaware State University's Health Professions Committee as one recruitment strategy to diversify enrollment of residents entering medical and dental school.

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<sup>20</sup> See the Appendix to review the 2007 DIMER Annual Report.

<sup>21</sup> Association of American Medical Colleges. Average Annual Tuition and Fees at Private Medical Schools. 2008-2009.

Notably, DIMER financial support to Jefferson Medical College has remained level (\$1.0 million per year) over the last twenty years despite rising costs incurred by the college. The cost of medical education has risen significantly over the past decades. For example, total JMC expenditures in 1991 were \$76 million, compared to \$285 million in 2007. DIMER remains the most economical alternative to Delaware having its own medical school. Based on current estimates, the initial startup investment, including the capital costs for new medical school facilities, can range from about \$100M to \$150M. This doesn't include the additional costs of developing a curriculum, annual operating costs, recruitment and retention of faculty, and fundraising for research activities. As our population grows and ages, the DIMER Program is a long-term approach that helps meet the future health care workforce needs of the State of Delaware. According to the Association of American Medical Colleges, the US will be at least 100,000 doctors short by 2025. There is far more benefit to the relationship with these two schools than just the reserved admission slots (see more information in attached DIMER Annual Report).

#### **2009 ACTION- Delaware Institute of Medical Education and Research (DIMER)**

- 1. Continue to demonstrate the critical value that the DIMER affiliation with Jefferson Medical College (JMC) and the Philadelphia College of Osteopathic Medicine (PCOM) provides and the benefits derived from the relationship to help recruit more providers to train and practice medicine in Delaware.**
- 2. Appoint a Health Care Commission member to the DIMER Board.**

<b>Delaware Institute for Dental Education and Research (DIDER)</b>
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In 2001, DIDER was transferred to the Health Care Commission, as a result of recommendations made by the state's Dental Care Access Improvement Committee. Subsequent legislation reconstituted and expanded the membership of the DIDER Board and expanded its scope in purpose. Two key responsibilities are to:

- Expand opportunities for Delawareans to obtain dental education.
- Develop ways to encourage dentists to practice in underserved areas and care for vulnerable populations.

#### **Issues:**

The shortage of dentists in Delaware is well established. A report on the supply and distribution of dentists was completed in 2006, which reemphasized the need to educate and recruit dental professionals to Delaware. Since its inception in 2001, the State Loan Repayment Program has successfully recruited 9 dentists to practice in underserved areas of Delaware. Efforts are being made to also begin recruiting dental hygienists to help make use of DIDER loan repayment funds.

During FY 2005, the DIDER Board identified access to dental school as a key priority in achieving its mission, and began reviewing options for providing opportunities for Delawareans



to attend dental school. Using the model developed by DIMER, the Board conducted discussions with several dental schools in the region and Temple University emerged as the ideal partner. In 2006, DIDER signed an agreement with the Maurice H. Kornberg School of Dentistry at Temple University which guarantees admission to six qualified students from Delaware in each entering class of dental students. This provides Delaware residents with an opportunity to receive quality education and training at a highly regarded regional dental school. The partnership also promotes opportunities for participating dental students to complete externship and residency training programs at facilities in Delaware.

Delaware residents are eligible to participate regardless of the location of their undergraduate educational institution. Students must meet Temple University's academic requirements and this program does not guarantee admittance. All Delawareans who are accepted and choose to attend Temple will be automatically admitted to the DIDER program; they are not required to fill out any additional applications. The Temple program was launched in state fiscal year 2007 (July 1, 2006 – June 30, 2007) when six slots were opened for incoming freshman. The program will grow by six slots over a four year period, culminating with 24 slots in state fiscal year 2010. This partnership helps promote opportunities for dental students to complete externship and residency training programs at facilities in Delaware.

Additionally, since tuition and fees at Temple (\$48,902 for the 2008-09 school year) is slightly higher than tuition at JMC and PCOM, and through the generosity of the Delaware State General Assembly, DIDER provided \$75,000 for 2007 and 2008 academic years for tuition stipends to be divided among the Delaware residents who attend Temple. Originally, each student received, at a minimum, a tuition stipend of \$5,000 per year and the remaining funds were allocated based on financial need. Budget reductions are anticipated in Fiscal Year 2010. In Fiscal Year 2010, if the funds are decreased, the stipend will be reduced to \$1,000 per student and the remaining funds will be allocated based on financial need— to be determined using Temple's financial aid formulas.

In 2008, the Commission and the Division of Public Health entered a collaborative partnership as a means to submit an Oral Health Workforce Development planning grant. Delaware was awarded \$200,000 in federal funding by the Health Resources and Services Administration, Bureau of Health Professionals an agency of the U.S. Department of Health and Human Services. The goal of the activities outlined in the grant proposal is to expand access to dental health care services and improve oral health outcomes in underserved areas of Delaware. The planning activities, including a feasibility study of three high-impact strategies, and a review of best practices will assist with the development of a defined implementation plan with action steps that address dental access needs, particularly in Sussex County. The DIDER Board will support the grant activities and provide input as necessary.

### **2009 ACTION- Delaware Institute for Dental Education and Research (DIDER)**

- 1. Continue support of DIDER and relationship with the Maurice H. Kornberg School of Dentistry at Temple University.**
- 2. Appoint a Health Care Commission member to the DIDER Board.**
- 3. Continue to support and aggressively promote the State Loan Repayment Program as a means to recruit dentists and hygienists to Delaware.**

**4. Support activities of the Oral Health Workforce one year planning grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County.**

<b>State Loan Repayment Program (SLRP)</b>
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The loan repayment program is designed to recruit health professionals to underserved areas of the state by repaying a portion of their educational debt in exchange for their commitment to practice in an underserved area in Delaware, for a minimum of two years. Practice sites may include public or private non-profit settings and private practices (solo or group).

The Delaware Health Care Commission (DHCC), in cooperation with the Delaware Higher Education Commission, administers the SLRP and is authorized to make awards for repayment of outstanding government and commercial loans incurred during undergraduate or graduate education (i.e. principal, interest and related expenses for tuition and educational costs). The program is funded annually through the DIMER (\$150,000) and DIDER (\$100,000) budgets appropriated to the Health Care Commission. Also, in August 2007 the DHCC competitively applied for and was awarded \$100,000 in federal funds annually for a three year project period through the U.S. Health Resources and Services Administration.

The SLRP provides educational loan repayment assistance to clinicians who agree to work at an eligible practice site in Delaware, which must be located in an area identified by the DHCC as being medically underserved. Health professionals participating in this program must provide services full-time (a minimum of 40 hours per week, not including on-call or travel time) for a minimum of two (2) years. Participants may re-apply for contract extensions in one-year increments, not to exceed a total of four (4) years of loan repayment. Extensions are granted at the discretion of the Loan Repayment Committee and are contingent upon the availability of funds. Priority is given to new applicants.

In cases where a practice site is located in a federally designated Health Professional Shortage Area (HPSA), state dollars provided for loan repayment can be matched dollar-for-dollar with federal funds. In these cases, the practice site must be a public or not-for-profit facility or a federally qualified health center. Additionally, health care providers must be HPSA appropriate for their discipline: primary care physicians in a Primary Care HPSA and dental providers in a Dental HPSA. Specific geographic locations in Delaware were recently federally designated as mental health HPSAs, which will increase the program's ability to place clinicians at sites that meet federal guidelines and qualify for the federal matching funds. Contracts with providers that will be supported using the federal match must include a stringent financial penalty for breach, in cases where a clinician fails to complete his or her contractual service commitment.

Private, public, federal loans for undergraduate or graduate education (i.e. principal, interest and related expenses for tuition and educational costs) qualify for loan repayment. In some cases, loan repayment funds may also be awarded to assist with capital loans (i.e. bank loans) for equipment expenditures to establish a practice in an area of high need. These awards are granted at the discretion of the Loan Repayment Committee and are contingent upon the availability of funds. In October 2006 official policies and procedures for capital expenditures were adopted by the Health Care Commission.

**Eligible health professionals include:**

<b>Advanced-degree Practitioners</b>	<b>Mid-level Practitioners</b>
Primary Care Physicians (MD and DO)	Registered Clinical Dental Hygienists
• Family Medicine	Primary Care Certified Nurse Practitioners
• Osteopathic Practitioners	Certified Nurse Midwives
• Internal Medicine	Primary Care Physicians Assistants
• Pediatrics	Clinical or Counseling Psychologists
• Obstetrics & Gynecology	Psychiatric Nurse Specialists
• General Psychiatry	Licensed Clinical Social Workers
Medical Oncologists	Mental Health Counselors
Pediatric Psychiatrists	Licensed Professional Counselors
General Practice Dentists (DDS and DMD)	Marriage & Family Therapists

Since 2006, new award thresholds have also been established for mid-level practitioners.

- *Advanced-degree Practitioners* may be granted up to \$70,000 total for a two (2) year commitment, or \$105,000 for a three (3) year contract.\*
- *Mid-level Practitioners* may be granted up to \$35,000 total for a two (2) year commitment, or \$52,500 maximum for a three (3) year contract.\*

\*Note that these figures represent the *maximum* award possible over 3 years; they are *not* guaranteed amounts, nor are they representative of recent awards. All awards are paid on a graduated scale.

Applications are accepted on a rolling basis. In 2007 the application review schedule for SLRP Committee, DIMER, DIDER meetings was re-arranged to reduce the length of the review and approval process to one-month, which proved effective and will be continued . The SLRP Committee reviews and ranks applications in priority order. This is based on the objective review of data (including public health indicators, the number and spatial distribution of providers practicing in Delaware, hospital needs assessments when applicable), the availability of funding, practice sites and (when applicable) the outcome of face-to-face interviews with selected applicants.

To-date, the following loan repayment placements have been made:

TOTAL PARTICIPANTS BY FISCAL YEAR										
	FY 01	FY 02	FY 03	FY 04	FY 05	FY 06	FY 07	FY 08	FY09*	TOTAL
Physicians Approved:	2	2	3	2	3	4	5	7	3	31
Mid-Level Approved:	n/a	n/a	n/a	n/a	n/a	0	2	4	0	6
Dentists Approved:	0	2	1	1	0	1	2	2	1	10
Total By Year:	2	4	4	3	3	5	9	13	4	47

\*FY09 statistics as of December 2008

Gender	
Female	29
Male	18

County	
New Castle	15
Kent	10
Sussex	22

Race/Ethnicity:	
White	28
Black	5
Hispanic	1
Asian	3
Indian	3
Korean	2
Pakistani	1
Cuban	1
Vietnamese	1
Not reported	2

Languages Spoken:	
Spanish	10
Chinese Mandarin	2
French	1
Indian (Hindi, Telugu, Tamil)	2
Korean	1
African (Urdu, Gujarati)	2
Vietnamese	1
Italian	1

### **Issues:**

A recognized disparity between DIMER and DIDER expenditures exists, due in part because DIMER has more eligible professions under its auspices and the funds are spent more quickly. Consideration will be given to future requests for increased funding for DIMER. There is also need to re-visit whether priority should be given to physicians over other eligible professionals.

In 2009, a retention policy will be developed to provide guidance to applicants on retention and establish criteria and parameters under which an individual can make application and be duly considered. Turnover rates among health care professionals, including physicians, are highest during the first three years of employment. Retention planning needs to be especially active during those first three years of practice.

## **2009 ACTION- State Loan Repayment Program**

- 1. Develop a policy that clarifies and defines health professionals funded under “retention”.**
- 2. Research strategies to recruit students from rural areas, as they are more inclined to remain and practice in rural and underserved areas beyond their loan repayment obligation.**
- 3. Discuss the issues with the General Assembly and engage feedback.**
- 4. Continue the current application review process and schedule.**
- 5. Evaluate and research state-only funded programs that provide loan repayment to “part-time” health professionals.**

<b>Health Professional Workforce Development Committee</b>
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The Commission’s Health Professional Workforce Development Committee (HWDC) is a public/private sector collaborative partnership to develop strategies to predict and prevent health workforce shortages. This Committee works to streamline the fragmented data collection systems that exist throughout the state today, examines the level of skill, education and training for a competent workforce, and will propose the development of sustainable policy recommendations to improve the supply, distribution and diversity of our health professional workforce. Primary goals and functions include:

- Centralize and coordinate a public/private sector collaborative partnership to develop strategies to predict and prevent workforce shortages
- Maintain a basic set of state-wide health personnel data that is standardized
- Diversify the health care workforce
- Evaluate education and training pipeline issues
- Explore recruitment and retention efforts
- Identify resources (financial and non-financial incentives) to support policy recommendations and where they come from
- Identify legislative priorities
- Identify competencies in the workforce that address health care needs

In 2007, a comprehensive study was completed of health education programs and “pipelines”, including the full array of programs available in Delaware; the supply of nursing and health professional faculty at colleges and universities; and the length of time required for students to complete their education and enter the workforce. For the purpose of this study, a total of 111 health education programs were identified at 23 educational institutions in Delaware, representing all of the known health training programs in the state. Of those 111 programs, 104 were found to be active programs with current student enrollments. A total of 89 responses to the survey were received, a response rate of 86 percent. A summary of findings can be found in the report, available in the online resource library at [www.dhin.org](http://www.dhin.org).

In 2008, a study designed to assess the supply and distribution of allied health professionals and pharmacists in the state was completed in partnership between the Health Care Commission, Division of Public Health and the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware. In 2007 surveys were distributed to over 5,000 health professionals in Delaware, including pharmacists, physical therapists, physician assistants, paramedics, speech/language pathologists, and radiologic technicians. The Committee was instrumental in shaping the design of the Allied Health Professionals capacity study and will determine next steps based on the key findings. The final report was released in the fall of 2008.

The Committee works closely with the Division of Professional Regulation to determine options for the collection of valuable health professional data through the on-line licensure process. Discussions are also underway in cooperation with the Division of Substance Abuse and Mental Health to create an online mental health professional directory as a resource for referrals within the provider community as well as consumers of health care services.

In 2008, the Commission and the Division of Public Health entered a collaborative partnership as a means to submit an Oral Health Workforce Development planning grant. Delaware was awarded \$200,000 in federal funding by the Health Resources and Services Administration, Bureau of Health Professionals. The planning grant could potentially turn into a multi-year grant to implement the strategies developed during the one year planning period. Specifically, the Commission will provide guidance and support to the project manager, hired by the Division of Public Health, help convene a steering committee, and hire a professional consultant to conduct a feasibility study that will comprise of cost estimates, an environmental analysis, and recommendations for implementation of three separate initiatives:

- 1) Creation of a case management program for children through Medicaid and State Children's Health Insurance Program (S-CHIP) enrollment to improve the oral health status of underserved families in Delaware
- 2) Enhancement of dental educational opportunities for dental hygienists and dental residents in southern Delaware to strengthen the dental workforce
- 3) Establishment of a multi-purpose dental clinic and training facility in Sussex County to improve access to care and expand training opportunities.

Finally, DPH plans to enter a contract with the Center for Applied Demography and Survey Research at the University of Delaware to conduct an analysis of the supply and distribution of auxiliary dental professionals (dental hygienists and dental assistants) in Delaware.

The Health Care Commission is the ideal agency to help facilitate the various planning activities proposed in the Oral Health Workforce grant and furthermore, it truly compliments its commitment to improve dental access. Additionally, the Commission's HWDC and DIDER Board will support grant activities as necessary.

In 2009 the Health Professional Workforce Development Committee will develop action items and policy recommendations for the Commission's consideration.

### **2009 ACTION- Health Professional Workforce Development Committee**

- 1. Continue the public/private sector collaboration to develop strategies to predict and prevent workforce shortages.**

- 2. Release key findings from the report on Allied Health Professionals.**
- 3. Support activities of the Oral Health Workforce one year planning grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County.**
- 4. Identify creative funding resources and where they come from to support policy recommendations.**
- 5. Prioritize and assess the pressing health workforce issues, and propose policy recommendations to improve supply, distribution and diversity of our health professional workforce. Recommendations will consider the following:**
  - Aging population**
  - Address mental health services as an essential component to overall health**
  - Increased diversity of the population**
  - Aging workforce**
  - Barriers to the workplace**
  - Increased burden of chronic disease**
  - Regional workforce and training issues**
  - Innovative financing for implementation strategies**

## Research & Policy Development – Research Reports

In order to provide accurate and up-to-date information to policy and decision-makers, the Health Care Commission contracts with the Center for Applied Demography and Survey Research (CADSR) at the University of Delaware to perform ongoing research. Reports and findings are published annually and made available to the public.

### ***Total Cost of Health Care and Delawareans Without Health Insurance***

The *Total Cost* report documents how much money is spent annually on health care in Delaware. It also identifies trends in health care costs and spending and impact on the state economy and labor market. The 2007 report includes a brief update on research on cost shift conducted by The Lewin Group for the Commission in 1999. A full replication and update of the original report will require the collection of additional data, including outpatient discharge data.

The *Uninsured* report analyzes and tracks the uninsured population in Delaware and their demographic characteristics. It is a very valuable resource for policy-makers and is updated annually.

### **2009 ACTION: Research Reports**

1. Continue to produce both the *Total Cost of Health Care in Delaware and Delawareans Without Health Insurance* reports annually.
2. Determine the requirements to update the Cost Shift report.
3. Re-visit efforts to expand data reporting to include out-patient procedures.

### **COST CONTAINMENT**

As Delaware considers comprehensive health care reform, advocates, stakeholders and policymakers will need to address cost containment and implement methods to control rising health care costs. While the costs of expanding coverage are significant, sustainable funding and shared responsibility will be necessary to support health care reform.

### **2009 ACTION: Cost Containment**

1. Identify and research methods to control rising health care costs.
2. Examine sustainable financing options that are substantial as well as reliable to support health care reform



## **HEALTH FUND ADVISORY COMMITTEE**

The Health Fund Advisory Committee was established by the General Assembly to make recommendations on how to spend the State's Tobacco Master Settlement Agreement revenue. The Commission has two representatives on the Committee, and is responsible for providing research and policy guidance to the Committee.

The Committee meets throughout the fall and finishes its work in December 2008 so that recommendations can be incorporated into Governor Minner's recommended budget for FY 2010.

### **2009 ACTION: Health Fund Advisory Committee**

- 1. Continue the current arrangement with Commission representation on the Committee and support from Commission staff.**

# Specific Health Care Issues & Affiliated Groups

## Health Resources Board

The Health Resources Board (HRB) oversees the Certificate of Public Review (CPR) process for all new medical capital construction and the acquisition of major medical equipment in the State. The Commission was previously represented by Herbert Nehrling and Robert Miller. Presently, new representation is needed.

HRB is required to:

- coordinate activities with DHCC, DHSS and other groups as appropriate
- develop a Health Resources Management Plan and submit to DHCC for review
- include continual care communities and other non-traditional long term care facilities in the scope of CPR, so long as the other facilities are identified by DHSS or DHCC

To date, most HRB activities have been project specific rather than policy oriented. However, recent policy changes have created opportunities for more interaction between the Commission and the HRB. The Certificate of Public Review process includes requirements for charity care, currently set at 2.75 percent of a facility's total gross revenue. Policy and enforcement procedures are under development subsequent to legislation being passed that granted the HRB authority to enforce the charity care requirement. Opportunities for HRB to coordinate with DHCC and the CHAP program for charity care policy implementation and enforcement are being explored. Currently, HRB defines "charity" as 350 % of the federal poverty level (FPL), while CHAP limits participation to 200% FPL.

### **2009 ACTION - Health Resources Board**

- 1. Continue coordination between DHCC and HRB staff; work to collaborate between CHAP and HRB's charity care policy.**
- 2. Appoint representation from DHCC to serve on the HRB.**

## Nutrition, Physical Activity, and Obesity Prevention Coalition/Network

In 2008, the Division of Public Health convened a summit inviting key stakeholders to discuss the development of a statewide Nutrition, Physical Activity, and Obesity Prevention Coalition. As a follow-up to the June summit planning session, a series of quarterly meetings of the workgroups or "Settings" for the planning process will be scheduled throughout the year. The settings will work to develop a strategic planning framework and strategies with objectives, responsibilities and a timetable. This combined effort will culminate in the creation of the comprehensive plan by June 2009. Settings include:

- Healthcare
- Worksites
- Families in Communities
- Environment and policy
- Schools
- Social Marketing and Communications

In October 2008, the first quarterly meeting was held and convened the six settings to assist with the development of a 5 Year Comprehensive Plan for the Nutrition, Physical Activity, and Obesity Prevention Project sponsored by the Division of Public Health. The name of the planning effort was formerly established as the Delaware Partnership to Promote Healthy Eating and Active Living. Further plans in 2009 include the development of recommendations from the settings and an inventory of existing efforts as well as a gap analysis.

In 2009, Commission staff will support the comprehensive planning process and provide input as necessary.

#### **2009 ACTION - Nutrition, Physical Activity, and Obesity Prevention Coalition/Network**

- 1. Support the development of a statewide coalition and participate as a collaborative partner to create a new comprehensive state plan with recommendations, objectives and action steps.**
- 2. Continue support and participation as necessary.**

<b>Mental Health Issues</b>
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Data gathering activities on the supply and demand of mental health services, including a survey of practitioners, focus groups of consumers and practitioners, and identification of best practices, is now complete. A comprehensive report was issued during the fall of 2006. Implementation of the recommendations is now underway in collaboration with Division of Public Health and Division of Substance Abuse & Mental Health. Staff will continue work on a plan for implementation with other key stakeholders.

Specific geographic locations in the state have been approved and federally designated as Health Professional Shortage Areas (HPSA) for mental health care providers, thereby supporting recruitment of mental health professionals to Delaware, particularly for Federally Qualified Health Centers and the State Loan Repayment Program.

#### **2009 ACTION- Mental Health Issues**

- 1. Continue to support the Committee's implementation planning as a result of the *Supply and Demand of Mental Health Services in DE (2006)* report and recommendations.**
- 2. Coordinate with the Division of Public Health (DPH) and the Division of Substance Abuse and Mental Health (DSAMH) on the new federally designated Health Professional Shortage Areas (HPSA) for mental health care providers, to improve recruitment and retention, particularly for Federally Qualified Health Centers and the State Loan Repayment Program.**

## Chronic Illness

In 2006, in response to a request by several members of the General Assembly, the Commission convened a Stroke Task Force, a sub-committee of the Commission's Chronic Illness Task Force in partnership with the American Heart Association / Stroke Association. The Task Force was charged with exploring the current stroke care environment, identifying potential areas of excellence as well as gaps in the stroke care system, and if warranted, making recommendations to develop and improve Delaware's statewide system of care.

The Stroke Task Force included experts in various related fields from all three counties to draw upon their knowledge and experience working together to improve Delaware's response to stroke. The scope of this analysis covered the entire continuum of stroke care including: prevention, emergency response, acute/sub-acute treatment, rehabilitation, and continuous quality improvement. The report includes a summary of data relating to stroke incidence and death rates, data on risk factors affecting stroke, a description of current stroke care systems in Delaware and recommendations for improvement. The Stroke report and recommendations were presented to the Chronic Illness Task Force in 2007.

Further support and attention on the increased burden of chronic illness will be critical in 2009. The total cost of health care (\$6 B) is increasing at a rate of 6 percent annually, and much of this expenditure can be attributed to the diagnosis and treatment of chronic diseases and conditions, including cardiovascular disease (primarily heart disease and stroke). Specifically, one of the most recent health care initiatives that the Commission has joined as a key strategic partner, in addition to several other community based organizations, is the development of planning activities initiated by the Primary Care Partnerships to Prevent Heart Disease in Women, which is supported by a three year grant awarded to Delaware from the US Office on Women's Health.

### **2009 ACTION - Chronic Illness**

- 1. Examine opportunities to address these issues over the next year.**
- 2. Continue coordination and support as necessary.**
- 3. Support the planning and development activities as a key collaborative partner of the Primary Care Partnerships to Prevent Heart Disease in Women, a three year grant awarded to DE from the U.S. Office on Women's Health.**

The current activities and action items summarized above, clearly demonstrate the commitment, the level of activity and the depth of partnerships in Delaware surrounding access to affordable and quality health care. Many of these initiatives have included the Delaware Health Care Commission as a key partner or lead convener, which has been instrumental to the small, but effective steps and progress made to expand and preserve coverage and move towards comprehensive health care reform.

# 2009 Action Steps: At-A-Glance

## 1. Uninsured Action Plan

### **Small Group Health Insurance Reforms**

1. Introduce legislation to implement recommendations in January 2009.

### **Small Group Insurance Pooling**

1. Continue to cooperate and work with the State Insurance Department in these and other endeavors.

### **Greenaght ® – Downstate Insurance Initiative**

1. Continue to follow the implementation and progress of this program and invite key stakeholders to update the Commission in the spring of 2009.

### **S-CHIP - Maximize Enrollment**

1. Evaluate the effectiveness of and actively participate in outreach strategies (i.e. Health Access America, Covering Kids & Families (CK&F), Healthy Delawareans Today & Tomorrow, and interagency collaboration) in Delaware to increase enrollment in S-CHIP -- registering eligible, yet non-enrolled children.

### **Community Health Center Marketing**

1. Examine key findings from the Delaware Federally Qualified Health Center (FQHC) Research Study and analysis conducted by John Snow, Inc. (JSI).
2. Collaborate with FQHC's and the Division of Public Health to develop and implement recommendations from JSI analysis (i.e. targeted marketing strategies; operational and performance improvement efforts; improve access/reduce barriers to care).

### **Universal Coverage**

1. Complete micro-simulation modeling of approaches to universal coverage to describe costs and financing more precisely (Single Payer and Building Blocks).
2. Invite Commissioners and members of the Small Business Insurance Committee to participate in universal coverage activities.

3. Receive and respond to modeling results, final analysis report and offer objective feedback.
4. Engage legislators and administration in modeling activities.

### **Community Healthcare Access Program (CHAP)**

1. Implement the following components of a CHAP Workgroup Action Plan:
  - Engage with AstraZeneca and recommend strategies for better coordination.
  - Continue to examine ways to expand primary care and prevention by building on the CHAP network.
  - Continue to examine opportunities for collaboration with the Health Resources Board.
  - Identify opportunities to blend Screening For Life Program (SFL) & Community Healthcare Access Program (CHAP) to:
    - Improve outreach
    - Gain greater administrative efficiencies
    - Track movement in and out of program as well as patient outcomes
    - Reduce eligibility and enrollment system barriers
    - Improve services to patients
  - Continue program evaluation (i.e. quality of care; access to services; outreach and enrollment); receive a report and determine next steps.

## **2. Information & Technology**

### **Delaware Health Information Network (DHIN)**

1. Stay informed and support DHIN development and implementation.
2. Support continued State funding with a request for funds in Fiscal Year 2010.
3. Continue administrative support.
4. Fill Board vacancies that are Health Care Commission appointments, as appropriate.
5. Actively engage in discussions and in the development of a sustainability plan.

### **3. Health Professional Workforce Development**

#### **Delaware Institute of Medical Education and Research (DIMER)**

1. Continue to demonstrate the critical value that the DIMER affiliation with Jefferson Medical College (JMC) and the Philadelphia College of Osteopathic Medicine (PCOM) provides and the benefits derived from the relationship to help recruit more providers to train and practice medicine in Delaware.
2. Appoint a Health Care Commission member to the DIMER Board.

#### **Delaware Institute for Dental Education and Research (DIDER)**

1. Continue support of DIDER and relationship with the Maurice H. Kornberg School of Dentistry at Temple University.
2. Appoint a Health Care Commission member to the DIDER Board.
3. Continue to support and aggressively promote the State Loan Repayment Program as a means to recruit dentists and hygienists to Delaware.
4. Support activities of the Oral Health Workforce one year planning grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County.

#### **State Loan Repayment Program**

1. Develop a policy that clarifies and defines health professionals funded under “retention”.
2. Research strategies to recruit students from rural areas, as they are more inclined to remain and practice in rural and underserved areas beyond their loan repayment obligation.
3. Discuss the issues with the General Assembly and engage feedback.
4. Continue the current application review process and schedule.
5. Evaluate and research state-only funded programs that provide loan repayment to “part-time” health professionals.

#### **Health Professional Workforce Development Committee**

1. Continue the public/private sector collaboration to develop strategies to predict and prevent workforce shortages.
2. Release key findings from the report on Allied Health Professionals.
3. Support activities of the Oral Health Workforce one year planning grant from the US Health Resources and Services Administration (HRSA) to expand access to dental care in Sussex County.

4. Identify creative funding resources and where they come from to support policy recommendations.
5. Prioritize and assess the pressing health workforce issues, and propose policy recommendations to improve supply, distribution and diversity of our health professional workforce. Recommendations will consider the following:
  - Aging population
  - Address mental health services as an essential component to overall health
  - Increased diversity of the population
  - Aging workforce
  - Barriers to the workplace
  - Increased burden of chronic disease
  - Regional workforce and training issues
  - Innovative financing for implementation strategies

## **4. Research & Policy Development**

### **Research Reports**

1. Continue to produce both the *Total Cost of Health Care in Delaware and Delawareans Without Health Insurance* reports annually.
2. Determine the requirements to update the Cost Shift report.
3. Re-visit efforts to expand data reporting to include out-patient procedures.

### **Cost Containment**

1. Identify and research methods to control rising health care costs.
2. Examine sustainable financing options that are substantial as well as reliable to support health care reform

### **Health Fund Advisory Committee**

1. Continue the current arrangement with Commission representation on the Committee and support from Commission staff.



## **5. Specific Health Care Issues & Affiliated Groups**

### **Health Resources Board**

1. Continue coordination between DHCC and HRB staff; work to collaborate between CHAP and HRB's charity care policy.
2. Appoint representation from DHCC to serve on the HRB.

### **Nutrition, Physical Activity, and Obesity Prevention Coalition/Network**

1. Support the development of a statewide coalition and participate as a collaborative partner to create a new comprehensive state plan with recommendations, objectives and action steps.
2. Continue support and participation as necessary.

### **Mental Health Issues**

1. Continue to support the Committee's implementation planning as a result of the *Supply and Demand of Mental Health Services in DE (2006)* report and recommendations.
2. Coordinate with the Division of Public Health (DPH) and the Division of Substance Abuse and Mental Health (DSAMH) on the new federally designated Health Professional Shortage Areas (HPSA) for mental health care providers, to improve recruitment and retention, particularly for Federally Qualified Health Centers and the State Loan Repayment Program.

### **Chronic Illness Issues**

1. Examine opportunities to address these issues over the next year.
2. Continue coordination and support as necessary.
3. Support the planning and development activities as a key collaborative partner of the Primary Care Partnerships to Prevent Heart Disease in Women, a three year grant awarded to DE from the U.S. Office on Women's Health.

# APPENDICIES

A) Delaware Health Care Commission: History and Background

B) Board and Committee Lists

Delaware Health Information Network (DHIN) Board of Directors

Delaware Institute for Dental Education & Research (DIDER) Board of Directors

Delaware Institute of Medical Education & Research (DIMER) Board of Directors

Health Workforce Development Committee

State Loan Repayment Committee

C) DIMER Annual Report 2009

## Delaware Health Care Commission: History and Background

The Health Care Commission is an independent public body reporting to the Governor and the Delaware General Assembly. It was created by the General Assembly in 1990 to develop a pathway to promote accessible, affordable, quality health care for all Delawareans. It was one of several steps taken following a report issued by the Commission's predecessor, the Indigent Health Care Task Force.

At the core of the Task Force recommendations was the recognition that the uninsured do in fact receive health care services in Delaware -- because hospitals do not turn them away. The Task Force cautioned, however, that this is not the most appropriate way to provide care. The hospital emergency department is one of the most expensive provider settings. In addition, many uninsured individuals forgo preventive and primary care, receiving treatment only after they are very ill and the care very costly. The group concluded that achieving a comprehensive effective solution would not be possible without taking a systemic, thorough look at the entire structure, financing and delivery of health care in Delaware.

Membership and work strategies build upon public and private knowledge and partnerships, and promote interagency governmental thinking and expertise in the health care arena.

The Commission provides an objective and informed forum for all stakeholders -- patients, insurers, employers, legislators, government agencies, health care providers, and others -- to identify issues, conduct research and achieve consensus around workable solutions. The Commission ensures that the policies that shape our health care system reflect the best thinking about ways to address the health care needs of Delawareans.

The Commission's activities come primarily in two forms: (1) research and (2) program management. Commission research provides intelligence on new and cutting-edge issues, measures progress, and provides objective knowledge and data upon which to base sound health care policy decisions. Program management assures the efficient implementation of projects to test new ideas and assures that existing programs achieve desired results.

The Commission's function as a policy-setting body rather than a service-delivery body gives it unique status within state government. The Commission was designed to allow creative thinking across agency lines and across the public and private sectors. Its initiatives are recommendations issued after intensive study of a particular aspect of the health care system or pilot projects designed to test new ideas. The Commission's unique status within state government, combined with the public/private nature of its membership, enables the Commission to make sound recommendations for positive change -- and facilitate and oversee their successful implementation.

The Commission has focused on access, cost, and quality in a variety of ways. In the early 90's access was addressed by targeted strategies designed to reduce the uninsured. The rapid emergence of managed care brought a shift in focus to addressing the disparity between the new evolving structure of the health care delivery and financing system and the existing government regulatory structure. This produced a new but important debate over how much should be regulated by government and how much should be left to free market forces.

In the mid 90's through the first few years in the 21<sup>st</sup> century, the Commission addressed access through strategies designed to ease the many health professional shortages that existed, and continue to exist today. The Downstate Residency Rotation pilot, loan repayment programs and special projects on access to dental care and the nursing shortage are all examples of initiatives designed to assure that Delaware has a sufficient supply of health professionals.

The Commission also strives to alleviate specific health conditions that are particularly problematic. Currently, the Commission is involved with initiatives addressing chronic illness, mental health services, medical liability insurance, physical activity and education, healthcare associated infections, and racial and ethnic disparities.

The Commission's mission is to promote access to affordable, quality health care for all Delawareans.

# Delaware Health Information Network (DHIN) Board of Directors

## **CHAIR**

**Robert J. White\***

*Delaware Physicians Care, Inc.*

## **VICE-CHAIR**

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*Center for Applied Demography and Survey Research  
University of Delaware*

## **SECRETARY**

**William E. Kirk, III, Esq.\***

*Blue Cross Blue Shield of Delaware*

## **BOARD MEMBERS**

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*Ex-Officio Budget Director Designee*

**Michael S. Katz, MD**

*Pediatric Anesthesiologist*

**Terry Feinour**

*Bayhealth Medical Center*

**Mark Meister\***

*Medical Society of Delaware*

**Stephen Groff**

*Ex-Officio Health & Social Services Designee*

**Linda Nemes**

*Ex-Officio Insurance Commissioner Designee*

**Joann Hasse\***

*Public Representative*

**Scott C. Reynolds**

*Bank of America*

**A. Richard Heffron\***

*Delaware State Chamber of Commerce*

**Paul Silverman, Dr. P.H.**

*Ex-Officio Public Health Director Designee*

**Steve Hess\***

*Christiana Care Health System*

**Robert J. Varipapa, MD**

*Neurologist, CNMRI*

**Thomas Jarrett**

*Ex-Officio Secretary, Department of  
Technology & Information*

**Barbara Vugrinec**

*Beebe Medical Center*

(\* Indicates Executive Committee Membership)

# Delaware Institute for Dental Education & Research (DIDER) Board of Directors

## CHAIR

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*Delaware State Dental Society*

## BOARD MEMBERS

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*Christiana Care Health System*

**Ryan C. Barnhart, DDS**  
*Delaware State Dental Society*

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*Delaware Dental Hygienist Association*

**Brian S. McAllister, DDS**  
*Higher Education Commission*

**Neil McAneny, DDS**  
*Delaware State Board of Dental Examiners*

**Gregory McClure, DMD, MPH**  
*Ex-Officio State Dental Director*

**Ray S. Rafetto, DMD**  
*Delaware State Dental Society*

**Wanda Gardiner Smith, DDS**  
*Public Representative*

**Vacant**  
*Delaware Health Care Commission*

## Maurice H. Kornberg School of Dentistry at Temple University Liaison

**Lisa Deem, DMD, Esq.**  
*Associate Dean for Admissions and Student Affairs*

# Delaware Institute of Medical Education & Research (DIMER) Board of Directors

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Sherman L. Townsend

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*Division of Public Health*

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*St. Francis Hospital*

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*Public Member, New Castle County*

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*Christiana Care Health Services*

**Vacant**

*Delaware Health Care Commission*

## Jefferson Medical College Liaisons

**Thomas J. Nasca, MD, FACP**

**David Paskin, MD**

## Philadelphia College of Osteopathic Medicine Liaison

**Carol A. Fox**

# Health Workforce Development Committee

## CO-CHAIRS

**Lisa C. Barkley, MD**

*Delaware Health Care Commission*

**Janice E. Nevin, MD, MPH**

*Delaware Health Care Commission*

## COMMITTEE MEMBERS

**Sonia Aguilar**

*DE Economic Development Office*

**Joan Barnwell**

*Division of Public Health*

**Judith A. Chaconas**

*Division of Public Health*

**Kathy Collison**

*Division of Public Health*

**Wendy Gainor**

*Medical Society of Delaware*

**Lucille Gambardella**

*Wesley College of Nursing*

**Carol Kuprevich**

*Division of Substance Abuse & Mental Health*

**Maureen Laffey**

*Higher Education Commission*

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*Christiana Care Health System*

**Gayle MacAfee**

*Division of Professional Regulation*

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*Medical Society of Delaware*

**Kenneth Peter Miller, PhD, RN, CFNP, FAAN**

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**Mary Moor**

*Division of Child Mental Health*

**Louis Rafetto, DMD**

*DIDER*

**Edward Rathledge**

*CADSR, University of Delaware*

**Penelope Seiple, RN, MSN, CNA, BC, CHE**

*Christiana Care Health System*

**Benjamin T. Shaw**

*Christiana Care Health System*

**Wayne A. Smith**

*Delaware Healthcare Association*

**Tibor Toth**

*CADSR, University of Delaware*

**Sherman Townsend**

*DIMER*



## State Loan Repayment Program Committee

### COMMITTEE MEMBERS

**Theodore Becker**

*Delaware Health Care Commission*

**Judith A. Chaconas**

*Delaware Department of Health & Social Services  
Division of Public Health*

**John A. Forest, Jr. MD**

*Delaware Institute of Medical Education & Research  
Board of Directors*

**Vacant**

*Delaware Health Care Commission*

**Gregory McClure, DMD, MPH**

*Delaware State Dental Director  
Delaware Institute for Dental Education & Research  
Board of Directors*

**Vacant**

*Delaware Institute for Dental Education & Research  
Board of Directors*

**Carylin Brinkley**

*Delaware Higher Education Commission*

**STATE OF DELAWARE**

**Delaware Health Care Commission**

**Delaware Institute of Medical Education and Research**

<p><b>Annual Report</b></p>
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**January 2009**

**State of Delaware  
Jack A. Markell, Governor**

**Delaware Health Care Commission  
John C. Carney, Jr., Chair**

**Delaware Institute of Medical Education and Research  
Sherman L. Townsend, Chair**

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Michael Alexander, MD  
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## **Introduction**

On behalf of the Delaware Institute of Medical Education and Research and its volunteer members, I am pleased to submit this Annual Report. It is evident from this report that DIMER has fully embraced its dual purposes of (1) providing educational opportunities for Delaware residents to pursue careers as Doctors of Medicine and Doctors of Osteopathy and (2) helping the state meet its health care needs.

Because Delaware does not have a state-supported medical school, the state through DIMER secures at least 20 admission slots for Delaware residents at Jefferson Medical College in Philadelphia, Pennsylvania and at least 5 admission slots at the Philadelphia College of Osteopathic Medicine (PCOM). DIMER also encourages Delaware residents who attend Jefferson and PCOM to return to Delaware to practice medicine.

DIMER provides Delaware residents admitted to Jefferson Medical College and PCOM with tuition supplements and an opportunity to compete for need based scholarships.

I am pleased to announce that 37 health care clinicians have been successfully recruited to underserved areas of the State as a result of the Delaware State Loan Repayment Program. Under the program, health care professionals are eligible to apply for funds to offset their outstanding medical education debt. In exchange, they must practice for a minimum of two years in an underserved area of the state, as identified by the Delaware Health Care Commission. This program should allow us to identify and eliminate our current provider shortages more quickly, while providing the flexibility we need to stay in step with our provider workforce needs as they change over time.

DIMER is committed to improving health care in Delaware. The members of the DIMER Board of Directors give freely of their time and without hesitation share their knowledge about medical education and the practice of medicine in our state. They are to be commended for their hard work and dedication to our state.

Sherman Townsend, Chair  
DIMER Board of Directors

## **History and Background**

The Delaware General Assembly in 1969 created the Delaware Institute of Medical Education and Research as an alternative to a state medical school. At that time there was a general shortage of physicians throughout the country, and states were moving to address this problem by establishing their own medical schools. In Delaware, however, there was a concern that such an undertaking was not financially feasible. Instead, Delaware created a public/private board to develop legal agreements, organize cooperative arrangements and disburse appropriated State funds to resolve this and other problems relative to medical education in Delaware.

The plan was to reserve seats for Delaware students in a major nearby medical school. At issue was the fact that most medical schools receive financial support from their home state, and in return accept a preponderance of students from that state. As such, Delaware residents were always “out of state” applicants and not given admission preferences usually extended to in-state residents.

The DIMER Board, on behalf of the State of Delaware, in 1970 established an agreement between DIMER, Wilmington Medical Center (now Christiana Care Health Services), the University of Delaware and Jefferson Medical College of Thomas Jefferson University, Philadelphia, Pennsylvania. Jefferson Medical College agreed to accept at least 20 Delaware residents each year who met the same academic requirements as other students, resulting in Jefferson functioning as Delaware’s medical school. Premedical programs at the University of Delaware were strengthened to prepare aspiring medical students for medical school admission.

During the early 1990s, the Delaware General Assembly asked DIMER to create incentives to encourage students attending Jefferson through DIMER to return to Delaware to practice primary care medicine. In Fiscal Year 1993, the loan program was converted from a need-based program to one based on service repayment. Under the program, students admitted to the DIMER program who were interested in returning to Delaware to practice primary care medicine applied for funding assistance. The loans were repaid with one year of medical practice in a designated primary care field for each year the funds were accepted.

In 1995, the Delaware General Assembly Joint Sunset Committee asked the Delaware Health Care Commission to conduct the first comprehensive review of DIMER since its creation. The General Assembly asked the Commission to review DIMER’s purpose as it relates to the health care needs of all Delawareans, examine current training and higher education needs, consider ways such needs might be more effectively met and consider DIMER’s activities in light of state needs and priorities.

The Commission, through a Primary Care Committee, conducted the review and in 1996 submitted its findings and recommendations to the Joint Sunset Committee. The report concluded that the original purpose of DIMER as an alternative to a state-sponsored medical school was sound. While some of its original purposes continued to reflect recommended activities for the future, the report noted that others no longer had practical application. The review and recommendations resulted in enactment of Senate Bill 418.

The statute reaffirmed the original purpose of DIMER as an alternative to a state-sponsored medical school and expanded the Board to reflect its statewide responsibilities.

One of the new opportunities presented by the statute was for the new Board to work with the Commission to identify state health care needs and craft programs or make recommendations to address them. The Board also has the authority to develop recruitment programs to attract medical school applications from minorities, residents of rural and under-served areas, and pre-medical students interested in practicing community and rural medicine.

DIMER also was charged with establishing a standing *Committee on Rural Health* to ensure the unique health care needs of rural Delaware are addressed in DIMER activities. The Committee released its first report and recommendations in 1999.

Placing the administration of DIMER in the offices of the Delaware Health Care Commission recognized the similar missions of the two agencies with regard to the state's efforts to meet its health care needs. It also addressed DIMER's need for a state agency "home" and accompanying resources such as staff and funding for supplies.

In 1999, new language in the budget epilogue called on DIMER to enter into discussions with the Philadelphia College of Osteopathic Medicine (PCOM) to allow the school to function as Delaware's school of osteopathic medicine. In 2000, this goal was accomplished. The measure also, for the first time, allocated funds for DIMER to recruit physicians, either medical doctors or doctors of osteopathic medicine. Recruitment tools include loan repayments. The first physicians were recruited to Delaware through the new State Loan Repayment Program in 2001. The program is discussed in more detail on page 9 of this report.

In 2001, the budget epilogue called on DIMER to restructure the grant/loan program in effect since 1993 into either a scholarship program or a loan program with more favorable tax consequences than the previous program. As a result, the former grant/loan program was phased out. A new program was implemented that provides Delaware residents admitted to Jefferson Medical College and PCOM with tuition supplements and an opportunity to compete for need based scholarships.

DIMER occasionally receives private donations. In 2002, it used the donations to provide one-time funding for two new programs: 1) A Summer Research Program to stimulate interest in pursuing a health related career; and 2) A Health Care Workforce Development Scholarship Program to create an incentive for people to re-enter the health care work force or pursue a new career in health care.

Two college students participated in the Summer Research Program and found it to be a rewarding experience. One student researched the effectiveness of the Flex-Guide ET Tube Introducer as an airway adjunct to decrease surgical cricothyroidotomy (surgically placing a hole in the patient's neck). The Associate Chair of Emergency Medicine at Christiana Care Health Services served as her mentor. The second student researched and defined the role of a Cancer Care Concierge. The Senior Vice President of Medical Affairs at Nanticoke Memorial Hospital served as his mentor. The findings were submitted as an article to the Delaware Medical Journal in August 2003.

There was an overwhelming response to the Health Care Workforce Development Scholarship Program. A total of 92 applications for the scholarship were received, clearly demonstrating the need for scholarship assistance for adults to enter health care fields.

A total of 17 scholarships were awarded to 5 males and 12 females; 10 New Castle County residents, 5 Kent County residents, and 2 Sussex County residents. The scholarships were distributed as follows:

- 2 - \$1700 each for radiologic technology at Delaware Technical & Community College
- 1 - \$1700 for a physical therapist assistant at Delaware Technical & Community College
- 1 - \$3600 for nursing at Beebe Nursing School
- 2 - \$3600 each for nursing at Delaware State University
- 1 - \$540 for the nursing refresher course at the University of Delaware
- 10 - \$3600 each for the accelerated nursing degree program at the University of Delaware



## **Delaware Institute of Medical Education and Research 2008 Accomplishments**

While continuing its mission of providing Delaware students an enhanced opportunity to pursue a medical education, DIMER also focused on the broader health care needs of the state.

### Admissions to Jefferson Medical College

Through DIMER, Jefferson Medical College accepted 30 Delaware applicants in its 2008 entering class. Of those, 22 matriculated.

### Admissions to Philadelphia College of Osteopathic Medicine

Through DIMER, the Philadelphia College of Osteopathic Medicine accepted 7 Delaware applicants in its 2008 entering class. Of those, 4 matriculated.

### DIMER Grant/Loan Program

The final grant/loan recipient completed residency training in 2008 and has been granted a deferment until July 2009 to complete a health policy fellowship.

In 2001, the DIMER Board of Directors evaluated the program in its entirety. The evaluation was in response to a number of concerns, including the potential tax liability of the forgiven loan, the attrition rate and the inability to predict what our health care workforce needs would be at the time the loans were forgiven. As a result, the former grant/loan program was phased out. A new program was implemented that provides Delaware residents admitted to Jefferson Medical College and PCOM with tuition supplements and an opportunity to compete for need based scholarships.

### Need Based Scholarship and Tuition Supplement Program

For the 2008-2009 academic year 72 tuition supplements were awarded to all four classes at Jefferson Medical College. Need-based scholarships were awarded to 13 freshmen, 14 sophomores, 13 juniors and 9 seniors for a total of 49 scholarships.

For the 2008-2009 academic year, 26 tuition supplements were awarded to all four classes at PCOM. Need-based scholarships were awarded to 5 freshmen, 4 sophomores, 3 juniors, and 6 seniors for a total of 18 scholarships.

### DIMER Loan Repayment Program

A State Loan Repayment Program was designed and launched to meet Delaware's more immediate recruitment needs. The program is administered by the Delaware Health Care Commission and DIMER in cooperation with the Delaware Division of Public Health and Delaware Higher Education Commission. Thirty-one physicians, four certified nurse midwives, and three certified nurse practitioners have been successfully placed in underserved areas as a result of the program.

### DIMER Committee on Rural Health

Several of the 1999 recommendations of the DIMER Committee on Rural Health were implemented, including those pertaining to the establishment of a Loan Repayment Program, monitoring Delaware's provider workforce capacity, developing a better understanding of the J-1 visa waiver program for international medical graduates, considering the importance of mental health in meeting the state's provider workforce needs, and continued support of the Downstate Residency Rotation Pilot Project.

### DIMER Dinners

DIMER traditionally holds an annual dinner for Freshmen and Sophomores at Jefferson Medical College to reinforce the relationship of the DIMER program to their attendance at Jefferson Medical College. The dinner is an opportunity to connect with Delawareans attending medical school and remind them of the state's desire that they consider returning to Delaware upon completion of their training. Along with the students, those who attend the dinner include members of the DIMER Board, and officials from Delaware's hospitals.

A second dinner targets Juniors and Seniors and is held in a restaurant off campus with the goal of recruiting them to Delaware for their residency training.

Each dinner is intended to foster conversation between students and hospital representatives about opportunities to enter residency training and practice in Delaware upon graduation. Both dinners are generally well attended, and considered successful by students, Jefferson Medical College, DIMER Board members and hospital representatives.

DIMER plans to continue the tradition of two separate dinners with Jefferson Medical College students.

In 2006 a new tradition began with a dinner with students at Philadelphia College of Osteopathic Medicine. The dinners have been very well attended and successful. DIMER plans to continue the tradition of an annual dinner with Philadelphia College of Osteopathic Medicine Students.

## **2009 Agenda**

For 2009, the DIMER Board plans the following projects:

Assure that at least 20 students are accepted by Jefferson Medical College.

Assure that at least 5 students are accepted by the Philadelphia School of Osteopathic Medicine.

Administer the Loan Repayment Program to health care professionals to underserved areas.

Monitor the relationship between DIMER students and Medical Scholars students from the University of Delaware who enter Jefferson to assure that an appropriate number of admission slots are available to both Medical Scholars and other Delaware students.

Continue the tuition supplement and need-based scholarship program.

Monitor Delaware's workforce needs to assure current and future DIMER activities reflect Delaware's needs.

Maintain a data bank of DIMER graduates to include their site of residency training and specialty of practice as a tool to assist in recruitment efforts.

## **DIMER Board: Composition**

The DIMER Board includes:

3 University of Delaware representatives, including 1 from the School of Nursing (now College of Health Sciences)

3 Medical Center of Delaware representatives (now Christiana Care Health System)

1 Delaware State University representative

6 representatives appointed by the governor, one from each of the state's three counties, one from the city of Wilmington, and two from medical residency programs other than those operated by the Medical Center of Delaware (now Christiana Care Health System)

1 representative appointed by the Association of Delaware Hospitals (now Delaware Healthcare Association)

1 representative appointed by the Higher Education Commission

1 representative appointed by the Delaware Health Care Commission

1 ex officio member, director, Public Health

## **DIMER Board: Purposes**

The purpose of the DIMER Board is to initiate, encourage and promote:

- The relationship with Jefferson Medical College as Delaware's medical school and ensure the admission of at least 20 Delawareans into Jefferson Medical College annually.
- Expansion of opportunities for Delawareans to receive training in the health and health-related professions when such Delawareans commit to practice in Delaware.
- Incentives for health and health-related professions to practice in Delaware.
- Continued development of a coordinated program of premedical, medical and graduate education among state public institutions, Delaware hospitals and Jefferson Medical College.
- Support of graduate and post-graduate medical and health training programs, with emphasis on those programs designed to meet Delaware's health care needs.
- Education and training programs in health fields and research in health and health-related fields, both basic and applied, including public health education, community health planning and health care costs.

## **ADVANTAGES DIMER PROVIDES TO DELAWAREANS**

DIMER provides a significant opportunity for the most qualified residents of Delaware to gain admission to medical school. The relationship Delaware has with Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA, through DIMER results in Jefferson reserving at least 20 admissions each year for Delaware residents.

Through the DIMER program, the odds of a Delaware resident getting accepted into Jefferson are about one out of three. The odds of someone from another state getting accepted, without a cooperative agreement such as DIMER, are about one in 50.

DIMER also has a relationship with the Philadelphia College of Osteopathic Medicine, which results in PCOM reserving at least 5 admissions each year for Delaware residents.

DIMER clearly creates a significant educational opportunity for Delaware residents who wish to pursue a medical education. It remains the most economical alternative to Delaware having its own medical school.

Another less visible impact of DIMER on health care in Delaware is the fact that Jefferson Medical College and PCOM are a source of residents for Christiana Care Health Services. About 75% of Christiana Care family practice physicians and 45% of Christiana Care internal medicine residents establish practice within 50 miles of their residency training experience.

## STATE LOAN REPAYMENT PROGRAM

The State Loan Repayment Program is administered by the Delaware Health Care Commission and DIMER in cooperation with the Delaware Division of Public Health and Delaware Higher Education Commission.

Upon completion of their education, physicians who choose to practice in a designated shortage area may apply for this program, which is designed to recruit health care professionals to underserved areas of Delaware. Participants receive awards for repayment of outstanding government and commercial loans incurred during undergraduate or graduate education.

Physicians participating in the program must provide services in an underserved practice setting for a minimum of two years with the option to extend the contract for up to two additional years. Practice sites may include public or private non-profit settings and private practices.

In 2006, new award thresholds were established for participants:

- *Advanced-degree Practitioners* may be granted up to \$70,000 total for a two (2) year commitment, or \$105,000 for a three (3) year contract.\*
- *Mid-level Practitioners* may be granted up to \$35,000 total for a two (2) year commitment, or \$52,500 maximum for a three (3) year contract.\*

\*Note that these figures represent the *maximum* award possible over 3 years; they are *not* guaranteed amounts, nor are they representative of recent awards. All awards are paid on a graduated scale.

Since the program's inception in 2001, a total of 38 health professionals have been placed in underserved areas. This is comprised of thirty-one physicians, four certified nurse midwives and three certified nurse practitioners that have been placed in underserved areas of the state.

## DIMER STATISTICS

Statistics show that Delaware's relationships with Jefferson Medical College of Thomas Jefferson University, Philadelphia, PA and Philadelphia College of Osteopathic Medicine function as important resources for Delaware students interested in attending medical school. Statistics also show that of the Delawareans who apply to medical schools nationally, most apply to Jefferson Medical College.

### Number of Delawareans that Applied and Were Accepted Nationally and by Jefferson Medical College

<b>Year</b>	<b>Applied to any Med School *</b>	<b>Matriculate d at any Med School</b>	<b>Applied to Jefferson</b>	<b>Accepted at Jefferson</b>	<b>Matriculate d at Jefferson</b>
2008	77	35	61	30	22
2007	92	39	50	29	20
2006	78	38	53	28	17
2005	78	35	62	23	13
2004	64	39	54	23	23
2003	71	34	56	23	23
2002	70	31	57	23	12
2001	64	31	50	21	16
2000	93	49	84	36	24
1999	82	50	72	32	30
1998	90	40	76	28	20
1997	100	41	91	34	26
1996	110	51	51	26	22

\* Source: Association of American Medical Colleges (AAMC), 2008  
[www.aamc.org/data/facts](http://www.aamc.org/data/facts)

**Number of Delawareans that Applied and Were Accepted  
by Philadelphia College of Osteopathic Medicine**

<b>Year</b>	<b>Applied to PCOM</b>	<b>Accepted at PCOM</b>	<b>Matriculated at PCOM</b>
2008	23	7	4
2007	33	9	7
2006	30	10	7
2005	21	7	7
2004	11	7	6
2003	25	6	7
2002	26	7	7
2001	23	4	4
2000	20	6	6

## **DIMER STUDENT APPLICATION AND SELECTION PROCESS**

Students interested in attending any medical school, including Jefferson Medical College, must apply through the American Medical College Application Service (AMCAS) in Washington, DC. After receipt of the AMCAS application, Jefferson identifies Delaware residents and sends them a special form to complete which assures them consideration under the DIMER program. Through DIMER, Jefferson reserves at least 20 admissions for Delaware residents. Applicants must meet the premedical academic requirements of Jefferson Medical College and Jefferson makes the acceptance decisions.

DIMER expanded its program to include a relationship with Philadelphia College of Osteopathic Medicine in 2000. Similarly, students interested in attending Philadelphia College of Osteopathic Medicine apply through the American Association of Colleges of Osteopathic Medicine Application Service (AACOMAS) in Chevy Chase, Maryland. After receipt of the AACOMAS application, PCOM identifies the Delaware residents for consideration under the DIMER program. Through the program, PCOM reserves at least 5 admission slots for Delaware residents. Applicants must meet the academic requirements of PCOM and PCOM makes the acceptance decisions.

### **DIMER Student Enrollment Status at Jefferson**

<b>Year</b>	<b>1st Year</b>	<b>2nd Year</b>	<b>3rd Year</b>	<b>4th Year</b>	<b>Total Enrolled</b>
2008	22	20	17	13	72
2007	20	17	13	24	74
2006	17	13	24	21	75
2005	13	23	23	12	71
2004	23	23	12	16	74
2003	23	12	16	24	75
2002	12	16	24	26	78
2001	16	24	26	22	88
2000	24	28	21	23	96
1999	30	16	22	22	90
1998	21	25	21	19	86

### **DIMER Student Enrollment Status at PCOM**

<b>Year</b>	<b>1st Year</b>	<b>2nd Year</b>	<b>3rd Year</b>	<b>4th Year</b>	<b>Total Enrolled</b>
2008	4	7	8	7	26
2007	7	7	7	4	25
2006	7	7	4	8	26
2005	7	4	9	10	30
2004	6	7	7	4	24
2003	7	7	4	6	24
2002	7	4	6	n/a	17

\* Program began in 2000, so no fourth year students were enrolled until 2003.



**JEFFERSON MEDICAL COLLEGE:**

**Geographic Distribution of Delaware Students Interviewed, Accepted and  
Matriculated**

**Year 2008 Entering Class**

<b>County:</b>	<b>New Castle</b>	<b>Kent</b>	<b>Sussex</b>
<b>Total DIMER Applicants</b>	47	9	5
<b>DIMER Applicants Interviewed</b>	33	4	4
<b>Acceptances Offered</b>	23	4	3
<b>Students Matriculated</b>	17	2	3

**PHILADELPHIA COLLEGE OF OSTEOPATHIC MEDICINE:**

**Geographic Distribution of Delaware Students Interviewed, Accepted and  
Matriculated**

**Year 2008 Entering Class**

<b>County:</b>	<b>New Castle</b>	<b>Kent</b>	<b>Sussex</b>
<b>Total DIMER Applicants</b>	19	3	1
<b>DIMER Applicants Interviewed</b>	11	2	1
<b>Acceptances Offered</b>	7	2	1
<b>Students Matriculated</b>	3	1	0

# JEFFERSON MEDICAL COLLEGE:

## Demographic Characteristics of Delaware Students Attending

### Race and Ethnicity (As self-reported by students)

Year	Race/ethnicity										
	White	Black	Hispanic	Asian	Korean	Japanese	Chinese	Filipino	Indian/Pakistani	Vietnamese	Hawaiian
2008	17			3	1						
2007	12	1		6						1	
2006	14		1	1	1						
2005	11			1		1					
2004	17					1	1	1	3		
2003	12			2			2	2	5		
2002	9	1						1	1		
2001	12				1		1		1	1	
2000	14	1		1	2		1		4		1
1999*	17	2			3		3		3		
1998	15	2	1	2			1				
1997	21	1					3			1	
1996*	18	1								2	
<i>Totals</i>	<i>172</i>	<i>9</i>	<i>2</i>	<i>13</i>	<i>7</i>	<i>2</i>	<i>12</i>	<i>4</i>	<i>17</i>	<i>5</i>	<i>1</i>

\* Indicates "no-response" answer(s) received in the race/ethnicity category

**PHILADELPHIA COLLEGE OF  
OSTEOPATHIC MEDICINE:**

**Demographic Characteristics of Delaware  
Students Attending**

**Race and Ethnicity  
(As self-reported by students)**

Year	Race/ethnicity				
	White	Black	Hispanic	Indian/Pakistani	Vietnamese
2008	4				
2007	5	1		1	
2006	4			2	1
2005	7				
2004	3	2		1	
2003	5			2	
2002	6		1		
2001	4				
2000	4				
<i>Totals</i>	38	3	1	6	1

**JEFFERSON MEDICAL COLLEGE:****Gender of  
Delaware Students Attending**

Year	Male	Female
2008	13	8
2007	10	10
2006	6	11
2005	6	7
2004	12	11
2003	12	11
2002	11	1
2001	8	8
2000	15	9
1999	18	11
1998	12	9
1997	17	9
1996	13	12
<i>Totals</i>	<i>153</i>	<i>117</i>

**PHILADELPHIA COLLEGE OF  
OSTEOPATHIC MEDICINE:****Gender of  
Delaware Students Attending**

Year	Male	Female
2008	2	2
2007	3	4
2006	3	4
2005	7	0
2004	3	3
2003	3	4
2002	4	3
2001	3	1
2000	4	2
<i>Totals</i>	<i>32</i>	<i>23</i>

## **DIMER LOAN STATUS**

New student loans were not awarded after 2000. The DIMER loan program was phased out and replaced with a tuition supplement and need based scholarship program.

In 2000, the last year of the program, four medical students attending Jefferson Medical College were awarded first time loans. Demographic characteristics of the loan recipients are as follows:

<u>Gender</u>	<u>Race</u>	<u>Geography</u>	<u>Years in School</u>
2 male	3 White	2 New Castle	2 1 <sup>st</sup> year
2 female	1 African American	2 Kent	2 2nd year

New student loans were not awarded in 1999, while the program was being evaluated and restructured.

In 1998, six medical students were awarded first time loans. Demographic characteristics of the loan recipients are as follows:

<u>Gender</u>	<u>Race</u>	<u>Geography</u>	<u>Years in School</u>
4 male	4 Caucasian	5 New Castle County	3 1st year
2 female	1 African American	1 Sussex County	2 2nd year
	1 Asian		1 3rd year

A total of 37 students had service obligations through the loan program by September 2001. No awards were granted in 2001, as the program was being phased out.

The first student to complete residency training did so in 1999 and began practice in New Castle County, Delaware.

Four students completed their residency training in 2000; three of the four have entered primary care practice in Delaware and one has decided to pay back his loans.

Six students completed their residency training in 2001; three have entered primary care practice in Delaware and three have entered cash repayment of the loans.

Four students completed their residency training in 2002; three have entered primary care practice in Delaware and one has been granted a one-year deferment from repayment while her spouse conducts research on a one-year grant in North Carolina.

Six students completed their residency training in 2003; four have entered primary care practice in Delaware; one has taken a position in Elkton, Maryland and continues to seek employment in Delaware; and one chose to pursue a specialty and pay back the loan.

Five students completed their residency training in 2004; two have entered primary care practice in Delaware; two requested a one-year extension to complete a Chief Residency program; and one was accepted into a fellowship.

Four students completed their residency training in 2005; one has entered primary care practice in Delaware; one plans to begin practicing in January 2006; one has been granted an extension until June 2006 to complete a Chief Residency; one will complete an additional year of training on primary care/muscle and skeletal care; two students withdrew from medical school and are repaying the loan; and one withdrew from medical school and had the loan cancelled.

No students with loans completed residency training in 2006 because there was one year when loans were not awarded while the program was being restructured.

Three students completed their residency training in 2007; one has been granted an extension until July 2010 while her significant other completes an Orthopedics Residency in Philadelphia, after which she plans to return to Delaware to practice; one has been granted an extension to complete a Cardiology residency, after which he will return to Delaware to practice Cardiology and enter cash repayment; one has entered primary care practice in Delaware; and a fourth student was academically dismissed and has entered cash repayment of the loan.

The final grant/loan recipient completed her residency in 2008, and was granted a deferment until July 2009 to complete a health policy fellowship.

*Note: Because the length of time it takes students to complete medical school and the length of residencies can vary, it is possible these dates may change.*

## EVALUATION OF THE DIMER GRANT/LOAN PROGRAM

Close monitoring of the DIMER loan program led the Board to determine that a formal evaluation of the program was needed. The evaluation began in 2000 with a review of the data. Initial findings indicated the need for changes to the basic structure. These findings included the following:

- The program did not effectively and efficiently help Delaware meet its immediate health care needs; it was generally seven years after the first loan installment until the service repayment obligation began.
- The program did not improve the ability of Delaware students to attend Jefferson Medical College. Students were approved for the loans after being accepted into Jefferson and securing other means of funding.
- Under federal tax law, it appeared that the funds might be considered taxable income to the students at the time they began to fulfill their service repayment obligation. This significantly reduced the financial advantage the loans were intended to provide.
- The attrition rate was almost 25 percent.

In 2001 the DIMER Board phased out the grant/loan program and replaced it with a tuition supplement and need based scholarship program.

The grant/loan program was phased out as follows:

- Grant/loan recipients up to 2000 retained their obligations to return to Delaware to practice.
- From that point forward the repayment obligation was removed from the scholarships and they were phased out in the following manner:
  - Year one – 2001-2002 academic year - recipients received 80 percent of the award
  - Year two – 2002-2003 academic year - recipients received 60 percent of the award
  - Year three – 2003-2004 academic year - recipients received 40 percent of the award
  - Grant/loan recipients were able to apply for a need-based scholarship to supplement their tuition.
  - Grant/loan recipients were able to apply for the loan repayment program in exchange for returning to Delaware to practice in a designated specialty and geographic shortage area.

The former grant/loan program has been replaced with a new tuition supplement and need-based scholarship program:

*Jefferson Medical College*

- The students selected during the June 20, 2001 interview process were each awarded a one-time scholarship of \$10,000 with no repayment obligation.
- All remaining 2001 freshmen were eligible to compete for a need-based scholarship; 11 scholarships were awarded, ranging from \$2,671 to \$19,476.
- All 2001 Delaware freshmen received a tuition supplement of \$1,000.
- All 2001 Sophomores, Juniors, and Seniors received a one-time tuition supplement of \$1,500.
- In 2002, it was determined that there were enough funds to provide tuition supplements and need based scholarships to all four classes immediately, rather than phasing a class into the program each year. This was largely due to the fact that fewer students were enrolled than estimated when the plan was developed. As a result, all Freshmen, Sophomores, Juniors and Seniors received a \$1,000 tuition supplement, and were eligible to compete for a need-based scholarship; 33 scholarships were awarded, ranging from \$1,448 to \$14,174
- In 2003, 68 students received a \$1,000 tuition supplement and were eligible to compete for a need-based scholarship; 43 scholarships were awarded, ranging from \$323 to \$10,840.
- In 2004, 68 students received a \$1,000 tuition supplement, and 2 students received a \$500 tuition supplement. All 70 students were eligible to compete for a need-based scholarship; 47 scholarships were awarded, ranging from \$1,112 to \$12,141.
- In 2005, 70 students received a \$1,000 tuition supplement and 72 scholarships were awarded, ranging from \$291 to \$12,114.
- In 2006, 75 students received a \$1,000 tuition supplement and 50 scholarships were awarded, ranging from \$383 to \$10,811.
- In 2007, 73 students received a \$1,000 tuition supplement and 47 scholarships were awarded, ranging from \$958 to \$10,396.

- In 2008, 72 students received a \$1,000 tuition supplement and 48 scholarships were awarded, ranging from \$246 to \$11,334.

*Philadelphia College of Osteopathic Medicine*

- All 2001 and 2002 Delaware Freshmen and Sophomores received a tuition supplement of \$1,000 and were eligible to compete for a need-based scholarship; 6 scholarships were awarded in 2001, ranging from \$2,207 to \$6,302; 9 scholarships were awarded in 2002, ranging from \$1,317 to \$5,430.
- All 2001 Delaware Freshmen received an additional one-time tuition supplement of \$500.
- In 2003, Delaware Freshmen, Sophomores and Juniors received a tuition supplement of \$1,000 and were eligible to compete for a need-based scholarship; 19 tuition supplements were awarded and 17 scholarships were awarded, ranging from \$882 to \$3,611.
- In 2004, Delaware Freshmen, Sophomores, Juniors and Seniors received a tuition supplement of \$1,000 and were eligible to compete for a need-based scholarship; 21 tuition supplements were awarded and 17 scholarships were awarded, ranging from \$1,523 to \$5,500.
- In 2005, 25 students received a \$1,000 tuition supplement and 20 scholarships were awarded, ranging from \$896 to \$4,379.
- In 2006, 23 students received a \$1,000 tuition supplement and 20 scholarships were awarded, ranging from \$935 to \$4,082.
- In 2007, 18 students received a \$1,000 tuition supplement and 14 scholarships were awarded, ranging from \$2,170 to \$5,828.
- In 2008, 26 students received a \$1,000 tuition supplement and 18 scholarships were awarded, ranging from \$1,566 to \$4,214.



## **TUITION AND FEES AT JEFFERSON MEDICAL COLLEGE, PCOM AND SURROUNDING STATES**

DIMER was formed as an alternative for establishing a medical school in Delaware. Through agreements with Jefferson Medical College and the Philadelphia College of Osteopathic Medicine slots are reserved for Delawareans who meet each school's entrance requirements. Since both schools are private, and therefore, carry high tuition rates, funds are provided to students in either the form of tuition supplements or scholarships based on financial need.

The DIMER Board is growing concerned that the high tuition of both schools may present barriers to some Delawareans taking advantage of the program. Tuition and fees at Jefferson are currently \$41,101 per year. Tuition and fees at PCOM are \$36,954 per year. The Board has recommended consideration of increasing the amount of funds allocated for scholarships and tuition supplements. When the original scholarship line amount of \$400,000 was allocated, Jefferson's tuition was \$25,235. As tuition has increased, the funds available for scholarships have not kept pace, and have not been increased since Fiscal Year 1996.

The high tuition, and corresponding prospect of accumulating significant debt upon graduation from medical school is regarded as a barrier to recruiting key target populations to the DIMER program.

The \$400,000 allocation for scholarships and tuition supplements at Jefferson Medical College has remained constant since 1996. During this twelve year period tuition has increased by about 68 percent from \$25,235 in 1996 to \$42,533 in 2008. A 68 percent increase in scholarship and tuition supplement funds would amount to an additional \$272,000 for students at Jefferson.

Funds were allocated for scholarships and tuition supplements at PCOM in 2000 and phased in over a four-year period at the rate of \$20,000 per class. During the past eight years tuition has increased by about 51 percent from \$24,725 in 2000 to \$37,509 in 2008. A 51 percent increase in scholarship and tuition supplement funds would amount to an additional \$40,800 for students at PCOM.

Tuition and fees (not including health insurance) for first year medical students at Jefferson Medical College and PCOM for the 2008-2009 academic year:

Jefferson Medical College	\$43,033
PCOM	38,034

Tuition and fees (not including health insurance) for first year medical students in public medical schools in surrounding states for the 2008-2009 academic year:

<u>School</u>	<u>Resident</u>	<u>Non-Resident</u>
Connecticut	\$25,548	\$48,195
Maryland	24,249	43,119
North Carolina	12,936	37,002
Pennsylvania State	35,034	46,274
South Carolina	25,576	61,258
SUNY- Downstate	19,370	34,070
SUNY – Upstate	19,956	34,656
Virginia	32,650	42,650
West Virginia	20,164	43,960

Tuition and fees (not including health insurance) for first year medical students in private medical schools in surrounding states for the 2008-2009 academic year:

<u>School</u>	<u>Resident</u>	<u>Non-Resident</u>
George Washington	\$46,267	
Georgetown	44,444	
Harvard	41,819	
Howard	34,081	
Johns Hopkins	39,108	
New York Medical	42,536	42,236
New York University	43,976	
University of Pennsylvania	44,251	
University of Pittsburgh	37,486	41,506
Temple	40,774	49,778
Tufts	48,992	
Yale	42,750	

## **STUDENT EXPENSE BUDGETS AT JEFFERSON MEDICAL COLLEGE AND PCOM**

In addition to tuition and fees, students at Jefferson Medical College and PCOM encounter additional expenses. The sum total of tuition, fees and other expenses is known as the standard budget for medical students.

### **Standard Budget for Medical Students at Jefferson Medical College**

The following is the standard budget for medical students at Jefferson Medical College, including tuition, room, board, books, supplies and transportation:

1 <sup>st</sup> year students	\$ 65,468
2 <sup>nd</sup> year students	64,930
3 <sup>rd</sup> year students	69,755
4 <sup>th</sup> year students	<u>65,744</u>
Total	\$265,897

### **Standard Budget for Medical Students at PCOM**

The following is the standard budget for medical students at PCOM, including tuition, room, board, books, supplies and transportation:

1 <sup>st</sup> year students	\$ 61,764
2 <sup>nd</sup> year students	60,929
3 <sup>rd</sup> year students	68,554
4 <sup>th</sup> year students	<u>67,569</u>
Total	\$258,816

## **Addendum I: DIMER Board of Directors**

### *Chair*

**Sherman L. Townsend**

### *Board Members*

**Brian M. Aboff, MD, FACP**

Christiana Care Health Services

**Vincent Lobo, Jr., DO**

Public Member, Sussex County

**Michael Alexander, MD**

A. I. DuPont Hospital for Children

**James Richards, PhD**

University of Delaware

**Anthony D. Alfieri, DO**

Public Member, Wilmington

**Jaime H. Rivera, MD, FAAP**

Division of Public Health

**Lisa C. Barkley, MD**

Delaware State University

**Ileana M. Smith, EdD**

Higher Education Commission

**David Bercaw, MD**

Christiana Care Health Services

**Wayne A. Smith**

Delaware Healthcare Association

**John A. J. Forest, Jr., MD**

Public Member, Kent County

**Steven J. Stanhope, PhD**

University of Delaware

**Galicano F. Inguito, Jr., MD, MBA, CPE**

St. Francis Hospital

**Carl Turner, MD**

Public Member, New Castle County

**Brian W. Little, MD, PhD**

Christiana Care Health Services

### *Jefferson Medical College Liaisons*

**David Paskin, MD**

### *Philadelphia College of Osteopathic Medicine Liaison*

**Carol A. Fox**

### *Staff*

**Paula K. Roy**

**Leah A. Jones**

**Marlyn Marvel**

Delaware Health Care Commission

**Stuart Drowos**

Department of Justice

**Maureen Laffey**

**Carylin Brinkley**

Delaware Higher Education Commission

## **Addendum II: DIMER Budget**

The Delaware General Assembly appropriated \$2,130,000 to the Delaware Institute of Medical Education and Research for Fiscal Year 2009. The amount was allocated as follows:

Jefferson Medical College	\$1,000,000
Philadelphia College of Osteopathic Medicine	250,000
University of Delaware	50,000
Christiana Care Health System	200,000
Scholarships/Loans	480,000
Loan Repayment	150,000
Total	\$2,130,000

### **Addendum III: Delaware Jefferson Medical College Students 2008 – 2009 Academic Year**

#### First Year Freshman

Ali, Mohsin  
Andrews, Jonathan  
Bonk, Michael  
Boyd, Laura  
Chiquoine, Elise  
Choxi, Hetal  
Feld, Samantha  
Harshman, Scott  
Henderson, Stacy  
Hinman, Benjamin  
Kamireddy, Samata  
Lee, Brian  
Margules, Andrew  
McSpadden, Ryan  
Mendelson, Aaron  
Mullan, Adam  
Ortlip, Timothy  
Rivers, Lane  
Rybicki, Steven  
Sammons, Sarah  
Swank, Amanda  
Vincent, Richard

#### Second Year Sophomores

Anttila, Ashley  
Brighthaupt, Sarah  
Devulapalli, Chaitu  
Dobson, Phillip  
Douglas, Lauren  
Fattah, Mohammad  
Field, John  
Gopalratnam, Anusha  
Gupta, Ratika  
Hummel, Chad  
Johnson, Caitlyn  
Kulkarni, Sanjay  
Molligan, Jeremy  
Reardon, Emily  
Sabesan, Arvind  
Saligrama, Madhuri  
Sarik, Jonathan  
Schuck, Alexandra  
Strang, Abigail  
Wilkins, Cy

#### Third Year Juniors

Cleary, Ryan  
Crowe, Elizabeth  
Davis, Erin  
Farach, Andrew  
Fierro, Michael  
Golebiewski, Stefanie  
Grenda, Tyler  
Hanley, Patrick  
Hansen, Patricia  
Healy, Kenna  
Juliano, Trisha  
Kim, Su  
Koterwas, Jennifer  
Liechty, Benjamin  
Schoch, Laura  
Witkin, Alison  
Yezdani, Mona

#### Fourth Year Seniors

Epstein, Rachael  
Guarino, Jeffrey  
Hurd, Jennifer  
Ikeda, Daniel  
Martin, Christopher  
Mascitti, Alexis  
Moroz, Leslie  
Pembroke, Thomas  
Quigley, Glen  
Seaton, Elaine  
Sheridan, Kelly  
Soltys, Anna  
Vaidyanathan, Nishant

## Addendum IV: DIMER Grant/Loan Recipient Status

Name	JMC Graduation	Residency Completion	2008 Status
Peluso, Susan	1995	1998	Completed Service Repayment
Anzilotti, Kent	1996	1999	Completed Cash Repayment
Clute, Stephen	1997	2000	Cash Repayment
Longo, Michael	1997	2000	Completed Cash Repayment
O'Brien, Matthew	1997	2000	Completed Service Repayment
Williams, Jane	1997	2000	Completed Service Repayment
Bowman, Adam	1998	Psychiatric Fellowship	Completed Service Repayment
Burke, Stephen	1998	2001	Completed Service Repayment
Simpkins, John	1998	2001	Cash Repayment
Phillips, Christine	1998	2001	Completed Cash Repayment
Schmeig, Andrea	1998	2001	Cash Repayment
Sordi, Mark	1998	2001	Completed Service Repayment
Brown, Barrington	1999	2002	Service Repayment
Grady, Matthew	1999	2002	Completed Service Repayment
Poppiti (Manfredi), Alissa	1999	2002	Completed Cash Repayment
Villasenor, Paul	1999	2002	Completed Service Repayment
Mancuso, Maria	1999	2002	Completed Service Repayment
Pak, Susan	1999	2002	Completed Cash Repayment
Davis, Angelique	2000	2003	Completed Cash Repayment
Nelson, Anne	2000	2003	Completed Service Repayment
Kirk (Neuberger), Deborah	2000	2003	Completed Service Repayment
Robinson, Amy	2000	2003	Completed Service Repayment
Zeberkiewic (Reinhardt), Claire	2000	2003	Completed Cash Repayment
Peters, Michael	1998	2003	Completed Cash Repayment
Hammer, Scott	2001	2004	Service Repayment
Young, Robert	2001	2004	Completed Service Repayment
Elliott, Daniel	2001	2005 Chief Residency	Service Repayment
Jordan, Trisha	2001	2005	Service Repayment
Pondok, Theresa	2001	2005	Completed Cash Repayment
Rappaport, David	2001	2005	Completed Service Repayment
Corradi, Emily	2002	2005	Completed Cash Repayment
Dassel, Jeffrey	2002	2005	Service Repayment
Dukes, Donald	2002	2005	Loan Obligation Cancelled
Jackson, Edward	2002	2005	Completed Cash Repayment
Lehane, Christina	2003	2006	Deferment until 2010
Davis, Angelique	2004	2007	Cash Repayment
McGillen, Brian	2004	2007	Service Repayment
Myers, Gene Robert	2004	2007	Completed Cash Repayment
Black, Kara Lynn	2005	2008 U of CA Residency	Deferment

## **Addendum V: Philadelphia College of Osteopathic Medicine Students 2008 – 2009 Academic Year**

### First Year Freshman

Cullen, Julia  
Molchen, Wallis  
Paoli, Matthew  
Santora, Joseph

### Second Year Sophomores

Batool, Amber  
Danko, John  
Doran, William  
Heckert, Anneliese  
McKiel, Holly  
Ratner, Aaron  
Wanjeri, Christine

### Third Year Juniors

Cohen, Valerie  
Khasat, Vikram  
Nashed, Nadia  
Nguyen, Lam  
Rutter, Heather  
Solanki, Anjali  
Walsh, Brian

### Fourth Year Seniors

Alexander, Christopher  
Jerusik, Brian  
Little, Eric  
Pirestani, Alireza  
Pryor, Brian  
Replenski, Stephen  
Richardson, Nicholas